27 CFR Part 5

Advertising, Consumer protection, Customs duties and inspection, Imports, Labeling, Liquors, Packaging and containers.

27 CFR Part 7

Advertising, Beer, Consumer protection, Customs duties and inspection, Imports, Labeling.

Authority and Issuance

PART 4—LABELING AND ADVERTISING OF WINE

Paragraph 1. The authority citation for 27 CFR Part 4 continues to read as follows:

Authority: 27 U.S.C. 205.

Par. 2. Section 4.32 is amended by adding a new paragraph (e) and OMB control number to the end of this section as follows:

§ 4.32 Mandatory label information.

* * * * *

(e) *Declaration of sulfites.* There shall be stated on a front label, back label, strip label or neck label, the statement "Contains sulfites" or "Contains (a) sulfiting agent(s)" or a statement identifying the specific sulfiting agent where sulfur dioxide or a sulfiting agent is detected at a level of 10 or more parts per million, measured as total sulfur dioxide. The provisions of this paragraph shall apply to: (1) Any certificate of label approval issued on or after January 9, 1987; (2) any wine bottled on or after July 9, 1987, regardless of the date of issuance of the certificate of label approval; and, (3) any wine removed on or after January 9, 1988.

* * * * *

(Paragraph (e) approved by the Office of Management and Budget under Control No. 1512-0469)

PART 5—LABELING AND ADVERTISING OF DISTILLED SPIRITS

Par. 3. The authority citation for 27 CFR Part 5 continues to read as follows:

Authority: 27 U.S.C. 205.

Par. 4. Section 5.32 is amended to redesignate paragraphs (b) (7), (8), and (9) as paragraphs (b) (8), (9), and (10), respectively, to add a new paragraph (b)(7) and to add the OMB control number to the end of the section as follows:

§ 5.32 Mandatory label information.

* * * * *

(b) * * *

(7) *Declaration of sulfites.* There shall be stated, the statement "Contains sulfites" or "Contains (a) sulfiting agent(s)" or a statement identifying the specific sulfiting agent where sulfur dioxide or a sulfiting agent is detected at a level of 10 or more parts per million, measured as total sulfur dioxide. The sulfite declaration may appear on a strip label or neck label in lieu of appearing on the front or back label. The provisions of this paragraph shall apply to: (i) Any certificate of label approval issued on or after January 9, 1987; (ii) any distilled spirits bottled on or after July 9, 1987, regardless of the date of issuance of the certificate of label approval; and, (iii) any distilled spirits removed on or after January 9, 1988.

* * * * *

(Paragraph (b)(7) approved by the Office of Management and Budget under Control No. 1512-0469)

Par. 5. Section 5.33 is amended by revising paragraph (b)(2), by redesignating paragraphs (b)(3), (4), and (5) as paragraphs (b)(4), (5) and (6), respectively, and by adding a new paragraph (b)(3) as follows:

§ 5.33 Additional requirements.

* * * * *

(b) * * *

(2) Statements required by this subpart, except brand names and the declaration of sulfites in § 5.32(b)(7), shall be separate and apart from any other descriptive or explanatory matters.

(3) If not separate and apart from other descriptive or explanatory matter printed on the label, the statement declaring the presence of sulfites shall be of a size substantially more conspicuous than surrounding nonmandatory labeling information.

* * * * *

PART 7—LABELING AND ADVERTISING OF MALT BEVERAGES

Par. 6. The authority citation for 27 CFR Part 7 continues to read as follows:

Authority: 27 U.S.C. 205.

Par. 7. Section 7.22 is amended by adding a new paragraph (b)(6) and OMB control number to the end of the section as follows:

§ 7.22 Mandatory label information.

* * * * *

(b) * * *

(6) *Declaration of sulfites.* The statement "Contains sulfites" or "Contains (a) sulfiting agent(s)" or a statement identifying the specific sulfiting agent where sulfur dioxide or a sulfiting agent is detected at a level of 10 or more parts per million, measured as total sulfur dioxide. The sulfite declaration may appear on a strip label or neck label in lieu of appearing on the front or back label. The provisions of this paragraph shall apply to: (i) Any certificate of label approval issued on or after January 9, 1987; (ii) any malt beverage bottled on or after July 9, 1987, regardless of the date of issuance of the certificate of label approval; and, (iii) any malt beverage removed on or after January 9, 1988.

* * * * *

(Paragraph (b)(6) approved by the Office of Management and Budget under Control No. 1512-0469).

Signed: August 11, 1986.

Stephen E. Higgins,

Director.

Approved: September 8, 1986.

Francis A. Keating, II,

Assistant Secretary (Enforcement).

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Part III

Department of Health and Human Services

Office of Human Development Services

FY 1987 Coordinated Discretionary Funds Program; Availability of Funds and Request for Applications; Notice

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Human Development Services

[Program Announcement No. HDS-87-1]

FY 1987 Coordinated Discretionary Funds Program; Availability of Funds and Request for Applications

AGENCY: Office of Human Development Services, HHS.

ACTION: Announcement of availability of funds and request for applications under the Office of Human Development Services' Coordinated Discretionary Funds Program.

SUMMARY: The Office of Human Development Services (HDS) announces the beginning of its Coordinated Discretionary Funds Program for Fiscal Year 1987.

Funding for HDS grants and cooperative agreements is authorized by legislation governing the discretionary programs of its constituent program administrations—the Administration for Children, Youth and Families (ACYF); the Administration on Developmental Disabilities (ADD); the Administration on Aging (AoA); and the Administration for Native Americans (ANA).

This program announcement consists of four parts. Part I provides background information, discusses the purpose of the HDS Coordinated Discretionary Fund Program, lists funding authorities, and briefly describes the application process. Part II describes the programmatic priorities under which HDS solicits applications for funding for projects. Part III describes in detail the application process. Part IV provides guidance on how to prepare and submit an application. All of the forms and instructions necessary to submit an application are published as part of this announcement following Part IV. Therefore, no separate application kit is available for submitting an application.

DATES: The closing date for receipt of applications under this announcement is December 15, 1986.

ADDRESSES: Application receipt point: Department of Health and Human Services, HDS/Grants and Contracts Management Division, 200 Independence Avenue, SW., Room 724–F, Washington, DC 20201 Attn: HDS–87–1.

This program announcement is available as an electronic document through the HDS Computer Bulletin Board. Organizations equipped with computers and modems may link to the bulletin board by calling (202) 755–1642.

FOR FURTHER INFORMATION CONTACT: Department of Health and Human Services, HDS/Office of Policy, Planning and Legislation, Division of Research and Demonstration, 200 Independence Avenue, SW., Room 724–F, Washington, DC 20201. Telephone (202) 755–4633.

SUPPLEMENTARY INFORMATION:

Part I—Preamble

A. Goals of the Office of Human Development Services

The four program administrations in the Office of Human Development Services, though varied, share a common mission: to reduce dependency and increase self-sufficiency among our most vulnerable citizens. Progress toward accomplishing this mission not only reduces demand for services but makes it possible for more Americans to live independent lives.

In order to be considered for funding under the Coordinated Discretionary Funds Program (CDP), each applicant must describe activities that contribute to meeting the goals of HDS. These goals are:

- To increase family and individual self-sufficiency and independence through social and economic development strategies;
- To target Federal assistance to those most in need; and,
- To improve the effectiveness and efficiency of State, local and tribally-administered human services.

The HDS Coordinated Discretionary Funds program is based on the principle that the well-being of the public is the responsibility of individuals, families and the communities in which they live. Human service needs are best defined and addressed through institutions and organizations at the level closest to the individual—State, Tribal and local governments, public agencies, businesses, private voluntary organizations, religious institutions, communities and families.

B. Mission of the Coordinated Discretionary Funds Program

The Coordinated Discretionary Funds Program is the major research and demonstration effort of the Office of Human Development Services. Through this program, HDS, together with not-for-profit, non-profit, voluntary and philanthropic organizations and local communities, attempts to analyze trends and anticipate social issues that will become paramount in the future; to improve the effectiveness and efficiency of human services by developing new techniques and approaches to deal with social issues; and to develop alternatives to traditional social service approaches.

HDS is primarily interested in providing funds for projects of immediate impact or which can become self-sustaining in a short period of time. The HDS Coordinated Discretionary Funds program is not intended to provide funds for ongoing social services or to serve as a supplemental source of funds for local activities which need operating subsidies.

C. Competitive Review of Applications

Applications which meet the screening requirements under Part III of this announcement will be reviewed competitively against the evaluation criteria (also published in Part III of this announcement) by qualified persons from the field of human services. HDS uses these field reviewer scores as the primary element in the selection process. The results of this review assist the Assistant Secretary and the Program Commissioners and other members of the HDS Senior Staff in deciding which applications should receive funding. However, only the Commissioner on Aging has the authority to approve applications for funding under Title IV of the Older Americans Act.

D. Findings from a Symposium on Youth in the Year 2000

On June 10, 1986, Health and Human Services Secretary Otis Bowen and Secretary of Labor William Brock, together with the National Alliance of Business, sponsored a meeting of national public and private leaders to discuss youth issues of critical importance to the Nation during the next fourteen years. Following that meeting, several interagency agreements have been signed between HHS and the Labor Department to formalize our working relationship on youth issues. In Fiscal Year 1987, the two Departments will consider joint funding of a number of qualified projects under priority areas dealing with disadvantaged, at-risk and troubled youth (e.g., 1.2.B, 2.1.A, 2.1.B, and 2.4.A).

Youth issues have become an increasingly important area of concern and a special focus for HDS and other components of HHS. Some of the more significant factors which are anticipated to shape issues of concern to youth into the year 2000 are:

1. For many American youth the future appears bright. Approximately 71 percent of young people graduate from high school. Over 7.5 million young people attend college each year, up 22 percent in the last decade. Demographic projections point toward a labor force

that will grow more slowly, providing opportunities for today's youth to reach for economic self-sufficiency as they complete the transition into adulthood.

2. The changing structure of the American family, however, remains a cause of concern. In 1982 22 percent of all children lived in single-headed families compared with 11.8 percent in 1970. It is projected that the number of single heads of households with children under 18 will increase 23 percent by the Year 2000. The number of children with mothers in the labor force rose by 5.8 million over the last decade to 33.5 million, or to nearly 60 percent compared with less than 50 percent 10 years ago.

3. The annual number of out-of-wedlock births to teenagers has increased 270 percent since 1960. One million adolescents become pregnant each year. Today, four out of ten 14-year-old girls will have at least one pregnancy before their 20th birthday. Six of ten women who receive public assistance had their first child as teenagers. We estimate that teenage pregnancies cost the welfare system $16 billion annually.

The prevention of adolescent sexual activity and adolescent pregnancy depends primarily on developing strong family values and close family ties. Since the family is the basic unit in which the values and attitudes of adolescents concerning sexuality and pregnancy are formed, programs which address the issues of sexuality and pregnancy need to operate within the context of the family. A main goal of prevention programs, as articulated by Secretary Bowen, is to encourage the postponement of sexual activity by promoting family involvement through increasing the amount and ease of communication about sexual topics between teens and their parents and encouraging positive changes in attitudes about the postponement of sexual activity among teens.

Male responsibility in preparing for future parenting contributions, both emotional and financial, is seen as an important component of this prevention focus. All too often, prevention efforts have focused only on the females and ignored the male.

4. Other problems confront youth as well. Approximately 3 million young people, 21 percent of all 14-to-17 year olds, have problems with alcohol. While marijuana use has declined since 1979, cocaine and PCP use are increasing. Accidents, homicide and suicide are the three leading causes of death for young people, and people under the age of 21 account for more than half of all arrests for serious crimes.

5. While most of these problems cross all social, economic and geographic boundaries, they are particularly acute among our nation's urban and rural poor. High school drop out rates in our large cities are approximately 50 percent. This is disturbing because occupational projections suggest that although the labor market in the year 2000 appears favorable to today's youth, the jobs of the future will require higher skill levels than those of today. There will be few well-paying jobs for the unskilled.

HDS has provided and will continue to provide short-term project support through the CDP for projects that:

- Build on the strengths of our nation's strong values of individual, family and community responsibility and interdependence;
- Promote positive values and practices among all young people;
- Target specific prevention efforts to at-risk youth, families and communities; and,
- Develop and implement creative community and family-based approaches to working with youth who have encountered major challenges to their development into independent and responsible citizens.

Specific priority areas related to youth issues in this announcement include 1.1.B, 1.1.C, 1.1.D, 1.1.E, 1.1.J, 2.1.B, 2.1.H, 2.3.A, 2.3.B, 2.3.C, 2.4.A, and 2.4.B.

E. HDS Partnerships with National and Community Foundations

To help us to develop priority areas for the CDP each year, HDS has extensive consultations with practitioners, State and local officials, national organizations, academics, and philanthropic groups.

Many foundations have supported important innovations in the human services and are developing an increasingly sophisticated body of knowledge. Last year, HDS officials met with representatives of a number of foundations to share ideas regarding priorities and to solicit recommended approaches for Federal consideration. These meetings led to a closer relationship between HDS and a number of foundations in the conduct of the Coordinated Discretionary Funds Program for Fiscal Year 1986.

In some priority areas, foundation staff participated in the review, selection and funding of projects. Some foundations are currently sharing with HDS officials the responsibilities for managing funded projects. HDS staff have also been involved in the process by which some foundations make financial awards to organizations.

This year we are continuing our relationship with community and national foundations through several priority areas.

G. Statutory Authorities

The individual statutory authorities under which grants and cooperative agreements will be awarded through the HDS Coordinated Discretionary Funds Program are as follows:

- *Head Start:* Head Start Act, Subchapter B of the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35, as amended (42 U.S.C. 9831 et seq.);
- *Child Welfare Services:* Adoption Assistance and Child Welfare Act of 1980, Pub. L. 96–272 (42 U.S.C. 626); section 426 of the Social Security Act, as amended, including the Child Welfare Training Grants Program (42 U.S.C. 5620);
- *Runaway Youth Program:* Runaway and Homeless Youth Act, as amended, Pub. L. 96–509 (42 U.S.C. 5701 et seq.);
- *Child Abuse:* Child Abuse Prevention and Treatment Act, Pub. L. 93–247 (42 U.S.C. 5101 et seq.);
- *Adoption Opportunities:* Title II of the Child Abuse Prevention and Treatment and Adoption Reform Act of 1978, as amended, Pub. L. 95–266 (42 U.S.C. 5101 et seq.);
- *Native Americans:* Native American Programs Act of 1974, as amended, Pub. L. 93–644 (42 U.S.C. 2991 et seq.);
- *Developmental Disabilities Special Projects:* Developmental Disabilities Act of 1984, Part E—Special Project Grants, section 162, Pub. L. 98–527 (42 U.S.C. 6000 et seq.);
- *Older Americans: Training, Research and Discretionary Projects and Programs:* Title IV of the Older Americans Act, as amended, Pub. L. 89–73 (42 U.S.C. 3031–3035e);
- *Social Services Research and Demonstrations:* Section 1110 of the Social Security Act, as amended (42 U.S.C. 1310).

Part II—Priority Areas

The programmatic priority areas of the Office of Human Development Services' Coordinated Discretionary Funds Program are listed as follows:

Section 1: Community and Family-Based Care

Topic 1: Support for Families:

- *1.1.A:* Support for Families Including Members with Developmental Disabilities
- *1.1.B:* Resolving Chemical Dependency Problems Within Native American Environments
- *1.1.C:* Models to Assist Teenage Parents in Preventing Child Abuse and Neglect

1.1.D: Parental Involvement in Head Start Programs
1.1.E: A Parent-Adolescent Mediation Program
1.1.F: Utilization of Adoptive Parent Groups to Support the Adoption of Special Needs Children
1.1.G: Services to Adoptive Families Who Experience Disruption or Dissolution
1.1.H: Improving Community Capability to Work with Adoptive Families of Children with Developmental Disabilities
1.1.I: Foster Care Placement Prevention
1.1.J: Corporate Partnership Models for Strengthening Families—Prevention/Outreach
1.1.K: Parenting Programs for Incarcerated Parents
1.1.L: Chronic Neglect of Children
1.1.M: Employer-Based Support for Family Caregivers

Topic 2: Community-Based Care and Improvements in Local Human Services
1.2.A: Community-Based Living Arrangements for Persons with Developmental Disabilities
1.2.B: Private Industry Council Partnerships—Linking Social Services and Youth Employment Services
1.2.C: Mental Health Services and the Child Welfare System
1.2.D: Improving the Quality of Educational Services for Children in Foster Care
1.2.E: Meeting the Health Care Needs of Children in Foster Care
1.2.F: Training of Foster Parents to Deal with Sexually Abused Children
1.2.G: Improving Protective Services Administration and Performance
1.2.H: Partnerships of Unions, Sororities, Fraternities, Service Organizations and Indian Organizations with Social Service Agencies in Support of Special Needs Adoption
1.2.I: Effective Strategies for Adoption Opportunities for Children in Residential/Group Care
1.2.J: Coordination of Court Actions in Child Abuse and Neglect Cases
1.2.K: Improving Child Protective Services on Indian Reservations
1.2.L: Improvement of State Child Welfare Licensing Programs
1.2.M: Adoption Opportunities for Older Children
1.2.N: Strategies for Recruitment and Retention of Foster Families
1.2.O: Prevention of Abuse and Neglect in Infants of Chemically Dependent Mothers

Topic 3: Improvement in Community Systems for Responding to the Needs of the Elderly:
1.3.A: Assessments of Community Service Systems and the Roles of Area Agencies on Aging (AAA's)
1.3.B: Aging Network Linkages—Improving Linkages Between the Community Health Care System, Especially Hospitals and Community Health Centers, and the Community Supportive Service System
1.3.C: Aging Network Linkages—Increasing State Agency on Aging Leadership Capacity to Assist Alzheimer's Disease Victims and their Families
1.3.D: Aging Network Linkages—Improvement in Emergency Services
1.3.E: Aging Network Linkages—Improving Linkages with Long Term Care Facilities
1.3.F: Improving Targeting of Services to the Vulnerable Elderly
1.3.G: Hospital Emergency Services—Tapping their Full Potential for Older Persons
1.3.H: Field-Initiated Proposals for Improving Community Service Systems for the Elderly

Section 2: Economic and Social Self-Sufficiency

Topic 1: Individual Self-Sufficiency
2.1.A: Expanding Employment Activities for Persons with Developmental Disabilities
2.1.B: Innovative Community Approaches to Entrepreneurial Activity with Native American High School Youth
2.1.C: Legal Assistance for Older Persons
2.1.D: Aging Health Promotion—Mental Health
2.1.E: Aging Health Promotion—Dental Health
2.1.F: Aging Health Promotion—Pedestrian and Motor Vehicle Safety
2.1.G: Transition of Head Start Students to Public Schools

Topic 2: Community Self-Sufficiency
2.2.A: Development of Models Applying the Enterprise Zone Concept to American Indian Reservations

Topic 3: Intergenerational Projects
2.3.A: Intergenerational Projects

Topic 4: Challenge Grants to Community Foundations
2.4.A: Job Clubs for Teenagers
2.4.B: Mainstreaming Troubled Youth

Section 3: Dissemination and Utilization

3.1.A: Expand or Improve Social Service Delivery to Native American Communities by Packaging and Disseminating Successful Approaches and/or Implementing Models in Other Native American Communities
3.1.B: Development of New or Replication of Successful Placement Efforts in Special Needs Adoption
3.1.C: Temporary Child Care for Handicapped Children and Children in Need of Protection
3.1.D: Assessment of Local Agency Adoption Efficiency

Section 4: Research and Evaluation

4.1.A: Development of Measures for Assessing the Performance of State Agencies on Aging
4.1.B: Assessment of the Relationship between Social Services for the Elderly Provided through Title III of the Older Americans Act and the Social Services Block Grant Program
4.1.C: Risk Assessment Systems Utilized by Child Protective Services in the Decision Making Process
4.1.D: Abused and Neglected Children Involved in Court Actions
4.1.E: Methods Used in Interviewing Child Victims
4.1.F: Removal of the Perpetrator versus Removal of the Victim from the Home: Effects on the Victim and the Family
4.1.G: The Relationship of Child Maltreatment to Childrens' Social and Emotional Development and School Performance
4.1.H: Assessing the Impact of Child Abuse and Neglect on Victims
4.1.I: Effectiveness of Child Abuse and Neglect Prevention Programs

Section 5: Education and Training

Topic 1: Education and Training in Aging
5.1.A: Statewide Short-Term Training and Continuing Education for Professionals and Paraprofessionals
5.1.B: Aging Content in Professional Academic Training
5.1.C: Minority Training and Development
5.1.D: State Agency on Aging Collaboration with Other Agencies
5.1.E: Orientation and Education for Elected Officials

Topic 2: Education and Training Related to Services for Children, Youth and Families
5.2.A: Stimulate Community College Involvement in Competency-Based Child Development Associate (CDA) Training for Child Care Givers
5.2.B: Child Abuse and Neglect Interdisciplinary Training

Topic 3: Child Welfare Services Training
5.3.A: Traineeships
5.3.B: In-Service Training
5.3.C: Collaboration between Schools and Agencies
5.3.D: Special Indian Grants

Section 6: Transfer of International Innovations

Section 1: Community and Family-Based Care

Topic 1: Support for Families:

1.1.A: Support for Families Including Members with Developmental Disabilities

Families which have elected to maintain members with developmental disabilities at home have traditionally been faced with two possibilities—they could provide care at home with little or no external support or they could opt for an institutional placement. Slowly, the merit of both supporting and enhancing the caregiving capacity of families is being recognized.

Some of the clearest guidance on this topic comes from Human Services Research Institute (HSRI) under work funded by ADD and the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE). These findings, presented in an article in *Exceptional Parent* (November, 1985, pages 10–22), document that all States but one make available some type of family support program. However, the programs vary significantly according to types of service provided, eligibility criteria, the number of clients targeted for service, and the amount of money to be expended annually on individual families. For a variety of reasons, families are often discouraged, rather

than encouraged from providing continued care in the family.

HDS is interested in projects designed to improve the effectiveness and efficiency of efforts to support families and family care. In particular, we will support demonstrations or systematic evaluation of demonstrations which address the following topics:

• *Involvement of families in health care.*

Many persons with severe handicapping conditions have chronic health conditions requiring atypical care and support throughout their lives. Children who are medically fragile demand extensive health care and ongoing medical service. While such care has greatly improved in the last decade, models have been slow to emerge for supporting families of children with these needs and involving families in health care and medical services through training. The training agenda in this area includes not only training for family members, but training for related medical personnel to increase their skill in dealing with the families and patients with handicapping conditions. Strategies are needed for promoting positive health practices and wellness among persons with severely handicapping conditions and their families. Community-based health services models are also needed.

• *Transitions to community living arrangements.*

The transition from natural homes to community living arrangements is potentially stressful for both the handicapped person and his or her family members. Data describing the decision-making process, the transition process and the individual family members' adaptation to the process are notably lacking. In addition to models for promoting healthy, family-supportive transitions, personnel must be trained to help families build new interaction patterns following the transition to community living.

• *Community support for families including persons with severely handicapping conditions.*

This area encompasses a variety of "generic" services for families including: transportation, recreation and leisure, access to buildings and activities, and education. The degree of access to community activities is subtly tied to a community's acceptance of persons and families with special needs in the full range of community life. Least restrictive community environments should be promoted through training and demonstration efforts.

• *Underserved family groups including minorities, teenage parents, and rural residents.*

Many intervention strategies and service delivery models have been designed for the middle income, two-parent family for which services are readily available. The particular needs of minority families, of teenage parents of children with severe handicaps and of families in rural areas are not well-documented. The affect of cultural differences on adaptation to a severely handicapped child has not been studied extensively. The development and evaluation of effective models to support these families is encouraged.

• *Continuum of family support services.*

Most demonstration models of family support have focused on families with young children. Strategies for supporting families with older school-aged and adult children with severe handicaps are needed. In particular, attention should be directed to the changing role and needs of siblings of persons who are severely handicapped and to the development of family support during the handicapped individual's adolescent and adult years. Again, particular attention should be directed toward families of persons who are medically fragile, those who have particularly challenging behavior, and those who are the most profoundly disabled.

In addition to incorporating the private sector, applications under this priority area should also feature the following components: multi-faceted approaches (rather than single service, such as respite alone), interagency collaboration (including, but not limited to State and local agencies, Developmental Disabilities Councils, Protection and Advocacy agencies, University Affiliated Facilities, and parent groups), and a discussion of how the proposed work will both interface with and depart from current family support programs within the State.

Proposals submitted should both build on and depart from currently funded work. To that end, a list of projects recently funded by HDS on the topic of support for families with members who are developmentally disabled can be obtained by writing: HDS/Division of Research and Demonstration, Room 724F, 200 Independence Avenue, SW., Washington, DC 20201 attn: Dianne McSwain, telephone (202) 755–4633.

Under this priority area, HDS plans to engage in cooperative activities with agencies including, but not limited to, the Rehabilitation Services Administration, Office of Special Education and Rehabilitative Services, Department of Education. Federal funding for projects in this priority area is limited to $100,000 per year with project periods not to exceed two years. Applicants are restricted to public or non-profit private entities.

1.1.B: Resolving Chemical Dependency Problems Within Native American Environments

Native American communities show widespread problems arising from chemical dependence. Disruption and dislocation of Native American family life are often associated with alcohol or other drug abuse. In a 10-year study of 12,000 Native American youth begun in 1975 by Colorado State University, it was found that the heaviest drug and alcohol users came from broken or unstable homes. Further, these youth felt that their family's life style was less successful in the "Indian way."

Another study by E.R. Oetting, et al. (1980) found that Native American youth who did not use drugs or alcohol consistently came from homes that had strong family sanctions against substance abuse. These families were perceived as being more successful in the "Indian way." A 1985 study of 2,000 Native American Youth aged 11 to 18, conducted by Velma Mason, showed that youth who did not use drugs or alcohol exhibited a high degree of family-oriented identity and perceived their families as maintaining traditional values. The reverse was found for Indian youth who reported drug or alcohol involvement.

During Fiscal Year 1985, the Administration for Native Americans funded a demonstration project called "Project Renewal." This project involved entire families in resolving problems caused by substance abuse. The Karuk Tribe of California has set up a model for family involvement with these significant elements:

1. Tribal elders and community leaders play a significant role in promoting traditional Karuk values among the families participating.

2. Family Service Workers work in the homes of needy citizens. These workers cultivate relationships with local and regional public and private agencies delivering human services. This includes educating agency professionals about Karuk cultural forms and implications for services design and delivery.

3. Cultural and family support groups meet weekly and a newsletter circulates among participants.

4. A summer camp brings the families together with the service workers and community elders. Held on Pow-wow grounds, families learn traditional survival skills.

The demonstration also prepared a film to disseminate information about the project. In addition, a demonstration camp has been planned for other tribal

leaders during the third year of the grant.

This is but one of a number of demonstration models which could be developed for use by Native American communities. Common to these models is the recognition that:

1. Substantial improvement in family life emerges from services sensitive to the Native American experience; and,

2. Effective service delivery involves the entire family.

Applications are solicited from American Indian tribes, Alaskan Native villages, Hawaiian groups and other Native American organizations for demonstration designed to show positive measurable outcomes in preventing or reducing chemical dependency. Proposals may present a comprehensive program for all families at risk in the project area or may address specific problem groups such as families where child abuse or neglect has occurred, families affected by suicides or suicide attempts, or single-parent families. Cooperative efforts including the general public and private agencies and/or organizations are encouraged.

Proposals should describe an extraordinary social or community involvement. Means for replicating the project must be included in the proposal. Federal funding for projects in this priority area is limited to $150,000 per project each year for up to three years.

1.1.C: Models to Assist Teenage Parents in Preventing Child Abuse and Neglect

As in FY 1986 HDS will seek applications in this area for FY 1987. Premature parenthood poses serious risks to the teen mother, her family, the teen father, and most significantly, the child. Teenagers are becoming parents at an increasingly earlier age. Teenagers now account for 16% of all live births and 22% of the low birth-weight babies.

Babies born to teenage mothers have a higher rate of infant mortality and greater incidence of developmental delays and abuse and neglect. These young mothers lack parenting skills and adequate knowledge of child growth and development. Early intervention with this high risk population is needed in order to reduce the potential for child abuse and neglect. Also of major importance is the encouragement of the teen father to meet his social and financial responsibilities to the child and to the mother of his child. The young parents are in need of a range of services that promote self-sufficiency, self-esteem, improve their skills in daily living, strengthen their capacity for parenthood and in general, improve their functioning as a family if possible.

Social service agencies, youth-serving agencies, public health agencies, and other private and public agencies provide a range of services to these young mothers and fathers, their babies and other family members. However, their efforts are often not coordinated, leading to fragmentation, gaps in service or duplication of services.

Particular consideration should be given by the applicant to:

(a) Identifying the procedures that will be used to determine those at highest risk.

(b) Developing state/regional/countywide coordination among agencies involved with providing direct services to this population.

(c) Developing collaborative efforts between two or more agencies to improve services and to follow-up with clients in the provision of services which promote self-sufficiency and better parenting skills such as health care, education (e.g., literacy or General Education Diploma—GED), housing, job training, day care, training in child development and parenting, and support group therapy.

(d) Expanding current program activities to enlist volunteers to support and provide assistance to the teen parent and child.

Applicants may wish to develop:

- Projects based in geographic locations with high concentrations of teenage mothers;
- Projects which are both innovative and cost effective in their approach to the problem;
- Projects which evidence collaborative service agreements with other related providers; and
- Projects which give sufficient promise of continuation after Federal funds terminate.

Cooperating and collaborating agencies should specifically address the level and type of involvement the agency is prepared to commit. Applicants should list organizations which will work on the project along with a short description of their contribution. Written assurances should be included with the application if available.

HDS anticipates funding 24 month projects having a Federal share not to exceed $75,000 per project, per year.

1.1.D: Parental Involvement in Head Start Programs

There are at least four major kinds of parent participation in local Head Start programs. They are:

1. Participation in the process of making decisions about the nature and operation of the program.

2. Participation in the classroom as paid employees, volunteers or observers.

3. Activities for parents which they have helped to develop.

4. Working with their children in cooperation with the staff of the center.

Most programs do involve parents in the local program. However, many programs have difficulty maintaining parent involvement and Regional Office review teams have difficulty assessing the level and quality of parent participation in local programs. There are a number of reasons for this low level of parent involvement: few descriptions of successful parent involvement programs; changing Head Start population being served (younger parents, more employed parents, diverse cultural groups); and, limited transportation for parents.

HDS will consider demonstration projects designed to increase parent involvement in Head Start programs and improve parenting skills as prime educators of their preschool age children. Proposals should address one or more of the following areas:

A. Programs that would involve parents one year prior to their children's entrance into the Head Start program and that would serve parents for one year after the children enter elementary school. These proposals should describe how parents would be recruited and selected for the program, what activities/programs would be provided for the parents, including training opportunities for various roles parents could play in the Head Start program.

B. Design programs that emphasize the role of parents as prime educators of their children. These programs should help the parents to access resources needed by children to succeed in elementary school.

C. Design programs that target a special parent group that may have unique attributes such as single parents, teen parents, fathers, migrants, isolated communities, multi-cultural populations, parents of handicapped children, etc.

Eligible applicants are local Head Start grantees.

HDS anticipates funding 24-month projects having a Federal share not to exceed $25,000 per project, per year.

1.1.E: A Parent-Adolescent Mediation Program Model

As more evidence points to adolescent abuse and neglect as a significant factor in runaway behavior, HDS is interested in developing innovative prevention strategies as part of the prevention-outreach goal of the Runaway and Homeless Youth Act.

The use of mediation to prevent and treat adolescent neglect was the focus of a pilot project which has resulted in a unique model program for use in conjunction with schools. The model was developed and tested by the Center for Community Justice (CCJ), a non-profit organization located in Washington, DC. It utilizes volunteers and focuses on truancy as a signal of possible family problems. This is especially significant for the runaway program since shelter experience has shown that truancy is almost always a precursor of runaway behavior.

Mediation is a method of dispute resolution that involves the use of a neutral third party to help people settle their own problems. The CCJ mediation model uses two mediators meeting with family members in two to four sessions of two to three hours each.

The factors that make mediation unique are:

1. The mediators are *neutral;* they do not make decisions for people or tell them what to do;
2. Mediation focuses on the *future* and ways to prevent problems from recurring;
3. Mediation helps people communicate in a positive way; and
4. Mediation teaches people ways of resolving their own problems and helps them take responsibility for their problems.

The majority of referrals to mediation come from school attendance officers and youth divisions of local police departments who recommend the Mediation Service for truants and their families when family problems are believed to contribute to or cause the truancy.

The initial results of the model program indicate that mediation can be used to work out issues of daily living and help to reduce family conflict. Most importantly, it helps family members to begin to communicate.

Every year for several years now over 50 percent of the youth served in runaway shelters have cited lack of or poor communication with parents as one of the major reasons for running away.

HDS will consider applications from runaway shelters and/or coordinated state or local networks of such shelters to further test this pilot model.

Interested shelters and/or coordinated networks should contact the Center for Community Justice to discuss the model and how it might best be adapted to their local communities. Proposals should describe extraordinary community involvement, especially from a junior or senior high school or schools. Written assurances should be included with the application if available.

A training of trainers approach will be used. Training will be provided for two people from each approved site. Proposals should describe how the model will be put into place once the training of trainers is complete. Project design should include concrete plans for evaluative, periodic feedback over the two-year period. HDS is especially interested in the possible impact on truancy rates.

Grantees are encouraged to utilize community resource persons with skills in mediation and conflict resolution such as the "Community Boards" program of San Francisco, California. One intensive training session will be conducted by CCJ in Washington, DC for all projects involved to train skilled trainers in the use and adaptation of this model. The training costs per person as well as per diem and travel costs should be contained in each proposed project budget. Information about the training costs can be obtained from Edna Povich at the Center for Community Justice, 918 16th Street, NW., Suite 503, Washington, DC 20026.

Project duration will be two years. Eligible applicants are runaway and homeless youth shelters or coordinated State or local networks of such shelters in partnership with one or more junior or senior high schools or both.

HDS anticipates funding 24 month projects having a Federal share not to exceed $65,000 per project, per year.

1.1.F: Utilization of Adoptive Parent Groups to Support the Adoption of Special Needs Children

Over the past two decades, adoptive parents have been effective advocates for children. They have challenged the term "unadoptable" by demonstrating that children with special needs can be placed with a family of their own. Adoptive parent groups and social service agencies have worked together to assist new adoptive families to integrate these special needs children into their families and have provided ongoing support to them.

HDS seeks applications from public or private non-profit agencies or organizations having statewide, regional (i.e. inter-State) or national membership to assist local or State adoptive parent groups to work with child welfare agencies. These adoptive parent groups will be responsible for activities which may include but are not limited to: adoption information and referral services, recruitment and orientation for prospective adoptive parents, and support to families following placement and legalization.

Applicants should be prepared to award small grants, not to exceed $5,000, to incorporated non-profit local or State adoptive parent groups to assist them in this effort. Applications should include criteria for choosing adoptive parents groups and the methods that will be used to request proposals from the groups; or applicants may list and describe the adoptive parent groups they propose to fund and include supporting documentation or other testimonies from such concerned groups. Written assurances should be included with the application if available.

Eligibility is limited to voluntary or public social service agencies, adoption exchanges, or other national regional or statewide adoption related organizations.

HDS anticipates funding 17 month projects having a Federal share not to exceed $75,000 per project.

1.1.G: Services to Adoptive Families Who Experience Disruption or Dissolution.

In studying disruptions (the removal of a child from an adoptive placement before legalization) and dissolutions (the removal of a child from an adoptive placement after legalization) in the adoption of children with special needs, we have learned that a large percentage of these children are later successfully placed in a different adoptive home.

However, we have little information about what happens to the adoptive family that experiences disruption or dissolution. For example, we do not know the extent to which the circumstances that resulted in disruption or dissolution are explored with the family by a social service agency; whether or not services are offered to the family to assist them in dealing with their feelings about the loss of the child or whether or not the family is given the opportunity to explore the appropriateness of the adoption of another child.

HDS is interested in applications from State, county, metropolitan or voluntary agencies that will develop, demonstrate and evaluate models of services to families that have experienced disruptions or dissolutions. Special attention should be given to families adopting minority children and/or children who have behavioral or emotional problems. Applicants should indicate the number of families to be served and describe products which will be worthy of national dissemination.

HDS anticipates funding 17 month projects having a Federal share ranging from $30,000 to $75,000 per project, depending on the number of disruption cases involved.

1.1.H: Improving Community Capability to Work with Adoptive Families of Children with

Developmental Disabilities

Families who are considering or who have adopted children with developmental disabilities frequently require services to assist them in understanding and meeting the needs of these children. The children may also need individual services to assist them in their adjustment in an adoptive home. In many communities there are multi-disciplinary diagnostic and treatment facilities that have the knowledge and expertise to provide these services. In addition, there are advocacy groups which are able to provide support and assist families in obtaining needed services. However, these organizations are often not known or readily accessible to adoptive families.

University Affiliated Facilities and Developmental Disabilities Councils could be of great assistance in special needs adoption by providing or assisting agencies and families to obtain pre-adoption diagnosis and evaluation of waiting children, preparation of families and by providing continued services through the placement, post-placement and post-adoptive periods. In addition, these entities can be helpful in linking adoptive parents with support and advocacy groups such as Associations for Retarded Citizens, Protection and Advocacy Agencies, United Cerebral Palsy and others.

HDS will consider projects to develop and demonstrate models of inter-disciplinary services for families who adopt children with developmental disabilities. These services should address pre-placement evaluation, diagnosis and preparation, as well as short and long term follow-up services. Models developed should be replicable and appropriate for dissemination.

Eligible applicants are University Affiliated Facilities, Developmental State Disabilities Councils and public or voluntary child welfare agencies. Applicants must document their ability to provide or obtain the services necessary for adoptive families. Applicants should demonstrate collaboration and joint commitment of a child welfare agency and UAF and/or DD Council. Applicants should list organizations that will work on the project along with a brief description of their contribution. Written assurances should be included with the application if available.

HDS anticipates funding 24 month projects at a Federal share not to exceed $75,000 per project per year.

1.1.I: Foster Care Placement Prevention

Under the Adoption Assistance and Child Welfare Act of 1980, States are required to develop a placement prevention program with an array of appropriate services, and since 1983, agencies are required to show that reasonable efforts have been made to avoid the necessity for placement. Early implementation studies show that States have developed law, policy, procedures and programs to meet these requirements but that in many instances actual resources for preventive services are still very limited.

Experience indicates that the change to a preventive approach is complex, requiring strong support from agency administrators and two to three years to complete reorientation of agency workers and community resources. Organizational and administrative structures and State and local financing practices are often barriers in shifting service provision from a child placement focus to family centered services. In addition, within States different approaches are needed to address preventive services in urban and rural areas.

In order to assist States, HDS has funded preventive service demonstrations in 5 States. The National Resource Center for Family Based Services is also funded to provide consultation and training to States on placement prevention programs. However, while most States have pilot projects or placement prevention programs in some metropolitan areas, few States have yet succeeded in providing these services to all appropriate children and families. This is significant because many States are experiencing an increase in the number of children in foster placement.

HDS seeks county, urban or Statewide demonstrations which draw on successful practices used by other States to identify children who are at imminent risk of removal from their homes and serve them through enabling their families to provide acceptable protection and care. (See *Annotated Directory of Family Based Services*, 1986, available from the National Resource Center for Family Based Services, University of Iowa, School of Social Work, N–240A Oakdale Hall, Iowa City, Iowa 52242.)

Proposals should address one or more of the following issues:

- Coordination of services to promote effective management of resources and delivery of services to families. In addressing issues of organization, applicants should describe how they will assure a family-based approach to service delivery. Attention should be directed to critical points of decision regarding allocation of resources, e.g., emergency response, assessment of family needs, crisis intervention, case planning, and provision and coordination of appropriate services. HDS is interested in creative approaches to both family assessment and decision making that will support staff in changing historic practices which encourage out-of-home placement.
- Promotion of adequate financing of family-based programs through increased flexibility in the use of funds, and the demonstration of cost effectiveness and program efficiency benefits when funding shifts are made from placement to in-home services.
- Demonstrations from rural consortia of counties or other rural regional structures, working in cooperation with the State agency, for the purpose of developing prevention and family-based programs across county lines.

Applications from such consortia should specify needs and resources including the development of natural helping networks, use of existing professionals such as school counselors, community mental health centers, State public health, agricultural extension and other such groups in planning and implementing a coordinated service system.

Funds may not be used to provide direct services.

HDS is interested in applications from State, metropolitan areas or rural or urban counties. Emphasis should be on developing a family based prevention service appropriate to the applicant's population, which can be used in similar situations by other counties or States. Applicants should list organizations that will work on the project along with a brief description of their contribution. Written assurances should be included with the application if available. HDS recognizes the need for States to use these various models to develop the capacity to offer appropriate family based services in all areas of the State. HDS anticipates funding 24 month projects having a Federal share not to exceed $100,000 per project, per year depending upon the scope of the proposed project (i.e. whether Statewide or less than Statewide).

1.1.J: Corporate Partnership Models for Strengthening Families—Prevention/Outreach

Prevention of runaway behavior; family conflict, abusive parenting, and other situations that cause family breakups and dysfunction at home and in the workplace are areas of concern not only to HDS but to communities nationwide. Family educational efforts and the provision of direct services have proved effective in reaching out to and

assisting families experiencing dysfunction.

Many corporations and health care providers have played an important role in this area by providing support to employees and their families through a variety of activities such as educational workshops, referral services and third party payments for the delivery of direct services. Much of this activity occurs under the general umbrella of the company's Employee Assistance Programs (EAP).

HDS seeks to continue the effort begun last year to develop models of partnerships between runaway and homeless youth centers or coordinated networks and corporations and health care providers that have existing or new Employee Assistance Programs. The purpose of the partnerships is to expand the capabilities of both centers and EAPs to provide educational and direct services to strengthen families in the workplace, and to prevent family dysfunction that results in runaway behavior. Each proposed project may include one or more corporations and/or one or more health care providers.

In 1986, five such partnership demonstrations were funded. Companies ranged in size from 20 employees to 60,000. They included manufacturing, chemical, high technology, research and planning, and computer service corporations. The projects included a wide range of approaches to partnerships with corporations ranging from lunch seminars, to educational workshops and family therapy. HDS will fund additional projects in this area so that there will be a sufficient project array to make the knowledge development as widely useful as possible.

Applications should address the development of education efforts or direct services based on a needs assessment of the families who are employees of the corporation and/or health care providers. Educational efforts could include issues such as preventing runaway behavior, adolescent abuse and neglect, teen suicide prevention, and improved parenting skills of parents with teenagers. Services could include counseling, group therapy, in-home family services, information and referral and other types of assistance.

An important part of each application should be the evaluation component. First, the evaluation component should include a statistical record of the utilization rate of all educational efforts and direct services and a description of the source of referral, hours, types of service provided, service outcomes for clinical services, and service status. This data should be used to provide a comparision of service usage and outcomes before and after the demonstration. Secondly, the evaluation component should include methods for determining client and employer satisfaction of the services provided. The third component of the evaluation should focus on determining the extent to which the project is viewed by the EAP director as a benefical, continuing priority in their current corporate Employee Assistance Program.

The corporations involved in the demonstration may be large or small; the health care providers may be a non-profit or for-profit hospital, HMO, or a free standing medical clinic.

HDS anticipates funding 17 month projects having a total Federal share not to exceed $70,000 per project. Eligibility to apply under this priority area is restricted to centers for runaway and homeless youth and coordinated networks. Each proposed project must demonstrate that the corporation and/or the health care provider partner was involved in the development of the project and is committed to its completion. Written assurances should be included with the application if available.

1.1.K: Parenting Programs for Incarcerated Parents

There is little information about the stigmas that are attached to parents who are incarcerated and their children. Past experience indicates that programs for these parents are critical factors in promoting emotional stability for both parents and children. Also, little is known about the impact on recidivism rates in correctional institutions where supportive parent/child programs may be in effect.

There is evidence to suggest that parenting programs can and do have a positive impact on incarcerated parents' sense of self worth and confidence in dealing with their children. This initial impact can lead to greater interest in self development and participation in GED, counseling, job skills development and career counseling program activities.

A successful project was conducted by Iowa State University in which positive family visitations and parenting skills were provided to incarcerated mothers. In-service training was provided to institution staff and volunteers, and resource material was upgraded to assist in preparing mothers for post-institutional life. Other successful program designs include the Mother Offspring Life Development (M.O.L.D.) program and Prison MATCH.

HDS and the National Institute of Corrections will fund demonstration programs which address the issue of parenting education, visitation type programs, and other programs for incarcerated parents with children and address the impact of these programs on incarcerated parents and their children. The project applicant should be aware of existing, successful programs such as the Iowa State University project. Data which indicate that a number of incarcerated persons were themselves victims of physical, emotional, and sexual abuse and what this finding may imply in developing a pertinent and successful program should also be taken into consideration. Applicants are also strongly encouraged to consider a volunteer component.

These projects are part of the overall HDS and National Institute of Corrections interest in strengthening families. Funds may be used for new or existing programs. Existing programs should be expanded to include an evaluation component that addresses the impact issues referred to above, i.e., increased parenting skills, improved self-image, greater interest in self development, job skills and participation in career counseling. Project applicants should be prepared to address not only the design and development of successful programs and their implementation and evaluation, but also the design and development of documentation and measures which will provide both qualitative and quantitative measures of the impact on project participants.

Variables should include but not be limited to: level of participation, i.e., one program component, several, etc.; development of parenting skills and child-parent relationships; and the impact of return or non-return to prison of parents within given time frames. Measures of recidivism and other data will be used as base line information for possible future projects and will not necessarily be interpreted as success or failure of a particular program.

Eligibility is limited to partnerships between correctional institutions, professional associations in the field with research capability, and research and educational institutions such as universities and colleges, graduate schools of social work, institutes or centers of child and family development. Applicants should list organizations that will work on the project along with a brief description of their contribution. Written assurances should be included with the application if available.

HDS anticipates funding 36 month projects having a Federal share not to exceed $60,000 per project, per year. Applicants shall focus separately on

incarcerated mothers or on incarcerated fathers.

1.1.L: Chronic Neglect of Children

Child neglect, as defined by the various states, is negligent treatment or maltreatment including the failure to provide adequate shelter, nourishment, medical care, education and supervision. Sixty-four percent of all substantiated child maltreatment reports (1976–1982) were instances of neglect. Many of these situations are chronic, requiring assistance over lengthy periods, or intermittently as families experience additional crises.

Few program models for working effectively with neglecting families have been developed and existing models usually have not differentiated among possible types and patterns of neglecting parents. National data (1976–1982) show that casework counseling was provided to 80% of all families served by child protective service agencies and that counseling is the service typically provided to neglecting families, although there is no evidence to indicate that this service is effective with chronically neglecting parents.

Other research has found that many neglecting parents, particularly mothers, suffer from depression and a variety of chronic health problems.

Finally, programs report difficulties in involving neglecting families, and in maintaining their participation in service programs.

The purpose of this priority area is to address those families which chronically neglect their children, and for which long-term dependency is an issue. HDS is interested in proposals to develop a cost-effective compensating support system for these families, using resources such as volunteers, parent aides and home visitors, to help the family identify and sustain the kinds of services and resources needed to keep the family going while dependent children are in the home. Each applicant should estimate the number or proportion of such families in its caseload, and provide the definition by which this number is determined.

The demonstrations should develop family assessment and treatment plans which, when tested against specific outcome criteria, can be evaluated for their effectiveness in compensating for client-family dependency. Project design should include an evaluation component. Applicants must list organizations that will work on the project along with a brief description of their contribution. Written assurances should be included if available.

HDS anticipates funding 2 to 5 36-month projects having a Federal share not to exceed $150,000 per project, per year.

1.1.M: Employer-Based Support for Family Caregivers

Many families have elected to maintain loved ones at home who are frail, handicapped, developmentally disabled, chronically or mentally ill. However, a recognition has emerged that some caregivers need support and training if they are to do an effective job and maintain their own well-being.

On June 23 and 24, 1986, HDS, together with other components of HHS sponsored a conference on support for family caregivers with 30 grantees, eight national associations, and three private foundations as well as other individuals and organizations interested in supporting caregivers. One of the recommendations that emerged from this conference was that the Federal government should stimulate the development of new approaches for assisting caregivers.

In this priority area, projects should focus on public and private employer caregiving policies, e.g. changes in leave policies, the development of new benefit policies, or the expansion of worksite service policies. Applicants must propose policy changes that address health, social and medical needs of both the dependent relative and the caregiver; policies that assist families in planning for future care needs and associated financial planning decision and decisions about alternative living arrangements; transitions from an acute care setting to a setting where ongoing services must be available.

The Department of Labor, which is interested in working with HDS in this area, will share information resources and may provide either technical assistance or funding support for selected projects. Applicants are encouraged to address the needs of multiple populations, including: families caring for frail or disabled elderly relatives and families in transitional stages of life who have a developmentally disabled member.

Topic 2: Community-Based Care and Improvements in Local Human Services

1.2.A: Community-Based Living Arrangements for Persons with Developmental Disabilities

The last decade has produced changes in residential arrangements. Public institutions have depopulated at a constant rate; the average size of residential facilities has decreased with corresponding increases in the number of small group residences; the number of children and youth in State MR/DD institutions has decreased; and State-based financing of community services has increased dramatically. In spite of the growing evidence regarding the benefits of community-based care, the development of community based residential programs continues to proceed without a comprehensive and unified national policy.

Although Federal efforts to support residential care in natural/adoptive families, foster homes and community based facilities have been supported by every administration since 1960, recent history presents a confused and irregular record. The largest Federal program for persons with mental retardation and developmental disabilities (MR/DD) is the ICF/MR (Intermediate Care Facilities for Mentally Retarded/Developmentally Disabled) which accounts for $2.657 billion (34.2%) of Fiscal Year 1985 Federal spending for these populations. Of far greater significance is that 82% of ICF/MR funds are being spent to maintain institutions with disproportionate numbers of severely and profoundly retarded persons. Meanwhile, most States have redirected their resources away from these operations to community based services.

In its Technical Report on Residential Services, the University Affiliated Facility (UAF) Networking Initiative reported many significant barriers to the community based provision of residential services for persons with developmental disabilities. (Copies are available from the Developmental Center for Handicapped Persons, Utah State University, UMC–68, Logan, Utah 84322.) These issues had to do broadly with needed policy reforms at Federal and State levels, more concerted efforts between UAFs and State Developmental Disabilities Councils in collaboration with other agencies and organizations, research and demonstration activities, broader dissemination of knowledge available and more organized transfer of the methods and models in existence, leadership training in areas critical to the planning of community based living arrangements, management of residential services and direct care worker training.

HDS is interested in research and demonstration projects which address each of several key issues. Topics on which proposals are sought include:

- Demonstration projects to eliminate systemic barriers to movement to the least restrictive environment. The trend of deinstitutionalization of persons with mild and moderate disabilities into community-based alternatives continues to prevail, while persons with more severe disabilities are remaining in the institutions. Design should focus on

shifting the burden of movement from the individual (by requiring demonstration of certain behaviors) to the residential/institutional system itself;

• Studies on the relationship between community setting and the acquisition of adaptive behavior skills. The full range of benefits resulting from community participation should be considered, particularly benefits related to improved quality of life (i.e. physical and social integration, variety, choice, relationships, health, and independence);

• Applications which propose to review relevant research or demonstrate models on the feasibility of heterogeneous groupings of persons with severe disabilities in small residences with persons who are less disabled. Increasingly, the field is revealing that serving only persons with severe handicaps in work, educational or residential settings results in multiple problems such as staff burn-out, inappropriate models of behavior for residents, and restrictions on community activity due to limited staff available for management purposes;

• Demonstrations designed to explore and document the relationship between facility accreditation/standards and actual client outcomes. Currently, information is not available to determine whether the application of standards to facilities has direct correlation to resident independence, productivity, development or satisfaction.

• The majority of states are designing community residential alternatives for six to eight residents. Pennsylvania is the only State placing four people or fewer in homes. Although smaller groups of people more closely resemble normal adult living situations, these smaller groupings also raise new questions about financial feasibility. Efforts examining the issues related to the number of persons residing in a single home are still needed.

Applicants addressing this priority area should clearly provide for the following in their proposals: interagency collaboration (including, but not limited to, State and local agencies, Developmental Disabilities Councils, Protection and Advocacy agencies, University Affiliated Facilities, and parent groups); discussion of how the proposed project will build on and depart from current work in the targeted state(s) or locality; and development of well-conceived strategies for evaluation, dissemination and utilization of the project findings. To that end, a list of projects recently funded by HDS on the topic of community based living arrangements for persons with developmental disabilities can be obtained by writing: HDS/Division of Research and Demonstration, Room 724F, 200 Independence Avenue, SW., Washington, DC 20201 attn: Dianne McSwain, telephone (202) 755–4633.

Under this priority area HDS plans to engage in cooperative activities with agencies including, but not limited to, the Rehabilitation Services Administration, Office of Special Education and Rehabilitative Services, Department of Education. Federal funding for projects in this priority area is limited to $100,000 per year with project periods not to exceed two years. Applicants are restricted to public or non-profit private entities.

1.2.B: Private Industry Council Partnerships—Linking Social Services and Youth Employment Services

There has been significant Federal interest in the problems of low-income youth for many years. These interests have been reflected in a number of ways, among which are some targeted specifically to older youth in foster care, to runaway and homeless youth and to unemployed low-income youth.

Youth in foster care are the focus of services designed to enhance their skills for independent living on emancipation from foster care, including preparation for the world of work. Congress recently enacted legislation mandating independent living services to adolescents in foster care.

Runaway and Homeless Youth shelter programs focus also on independent living where reconciliation with families is not possible. Under the Department of Labor's Job Training Partnership Act (JTPA), funds have been earmarked for services aimed at promoting youth self-sufficiency at the local level through a partnership of Private Industry Councils (PICs) and elected officials.

What is often lacking at the local level is effective coordination and reinforcement among these various youth-serving programs for the development of program models aimed at promoting the self-sufficiency of these disadvantaged youth.

This priority area seeks the development of innovative, holistic program models to address the needs of two discrete youth populations: older adolescents in foster care or recently emancipated from foster care; and/or homeless youth being served in independent living programs in runaway youth centers or other youth serving agencies.

Many child welfare programs at the State and local levels are responding to the growing population of youth in their foster care caseloads; teenagers account for approximately 44 percent of those caseloads. Additionally, a growing proportion of these teenagers are staying in care for longer periods, up to emancipation at age 18 or 19. These agencies are developing programs geared to preparing youth for independent living, including preparation for the world of work.

Runaway and homeless youth shelters see a different group of adolescents. The shelters are able to reunite more than half of the runaways and find suitable living arrangements for most of the others. The homeless youth, however, are often entirely alienated from their families and must become prepared for independent living through a variety of public and private youth serving agencies.

HDS is seeking the establishment of community-based partnerships between those responsible for planning and allocating youth training and employment resources, i.e. local JTPA administering agencies (PICs), and those responsible for providing social support services to youth, i.e. foster care service agencies and local runaway and homeless youth shelters and/or local networks of shelters and other youth service providers.

Through joint planning and a case management approach these demonstrations will link social services and employment services into an integrated plan to assist these youth to achieve self-sufficiency.

Any of the three entities is eligible to apply as the designated local lead agency as long as agreements among the other agency(s) are reached. Written assurances should be included with the application if available. HDS encourages local JTPA administering agencies (PICs) to take on the leadership role in the design and development of the proposed projects.

What we seek foremost is the gaining of knowledge and perspective among the organizations that will lead to more effective coordination and services for these youth at the local level.

While the major focus is on local community-based efforts, HDS will consider one or two projects in which State Child Welfare Agencies, State JTPA administering agencies and coordinated State networks of runaway and homeless youth shelters and youth service providers propose efforts within the State. Applicants should state clearly how on-site coordination and collaboration among sites will be accomplished.

The following organizations endorse this priority area: the National Alliance

of Business; the National Association of Private Industry Councils; and the National Youth Employment Coalition.

HDS anticipates funding a series of 36 month demonstration projects. The level of funding would be approximately $50,000 per project. PICs are encouraged to use JTPA resources in support of these projects; however, JTPA funds must be used for JTPA purposes.

1.2.C: Mental Health Services and the Child Welfare System

Children in the child welfare system and the families who relate to them (whether birth, foster or adoptive) often have multiple problems which require the skills and expertise of mental health services in addition to child welfare services.

The purpose of this priority area is to support collaborative efforts between community mental health services and child welfare services to develop and/or expand specialized treatment skills and resources for the children and families served by the child welfare system, and to insure that there are mechanisms in place which permit and encourage child welfare agencies and families access to these resources and services.

The types of mental health problems of child welfare clients are not unique, but these clients exist in familial contexts which can be different from other mental health clients. Extensive support is frequently required for addressing the needs of and providing treatment for children and their parents in these families.

Protective services interventions that support the child in his own home rather than in foster care are effective, therapeutic, and in most cases cost-effective. The coordination and collaboration between mental health services and child protection services can be especially helpful during the investigative period when the child and family are dealing with the immediate crisis and the child is at greater risk of being removed as well as after the child has been removed and efforts are being made to reunite the family. In addition, physically and sexually abused children often need long-term psycho-therapeutic support to help them deal with the trauma, build self esteem and learn to relate positively to peers and adults.

Many children placed in foster care have a variety of developmental problems, behavioral symptoms, depression and mental health problems as a result of inadequate parenting, instability, family disruption, physical and sexual abuse and neglect. Efforts should address early identification of children who appear to be having emotional and adjustment difficulties and the provision of appropriate mental health services to the child and assistance to the foster parents in understanding and managing the child's behavior.

Families who adopt children with special needs often need mental health services. These children come into adoption with their own history and life experiences that are quite different than those of their new family. Services may be needed to help the child deal with previous separations and assist family members to integrate the child into the family. In addition to family sessions, individual treatment for the adopted child may be indicated. Adoption is a life-long process and mental health services may be needed years after an adoption occurs.

HDS will fund projects that demonstrate inter-agency coordination and improved mental health services to child welfare clients. Projects should specify methods and models for coordinated planning, resource development and systems integration that will provide a continuum of home and community-based services to assist in strengthening families, preventing placement, providing early intervention, reducing waiting periods for service while demonstrating cost-effectiveness. Public agencies as well as private non-profit child welfare or mental health agencies are encouraged to apply. Consortia of private and public agencies that demonstrate collaborative planning and joint commitment of resources, including personnel, are encouraged. For applicants other than public child welfare agencies, evidence of support from the public child welfare agency (local/regional/State) is highly desirable. Written assurances should be included with the application if available.

HDS anticipates funding 24 month projects having a Federal share between $100,000 to $200,000 per project, per year with a possibility of renewal for an additional 12 months. It is expected that projects proposed by both public and private non-profit applicants will be funded. Applicants may address one or more topics: protective services, adoption, or foster care.

1.2.D: Improving the Quality of Educational Services for Children in Foster Care

Many children in foster care have educational deficits as a result of frequent moves, lack of parental direction, learning disabilities and family disruption. (These deficits have been documented in two studies: Fanshel and Shinn's Longitudinal Study of Children in Foster Care, 1978 and Fanshel, Grundy and Finch's Serving Children at Risk in Foster Family Care, 1985—and in Child Welfare Research Notes #15 by Charles Gershenson). Many times these children are not adequately diagnosed or properly placed in the school system and their needs may be overlooked when they move to a new placement, or return home. Foster care agencies may not have the internal resources, parental supports, relationships with advocacy organizations or effective linkages with the school system to ensure that children with special educational needs are properly served.

HDS is interested in proposals that demonstrate effective methods to meet the special educational needs of children in foster family care, and that emphasize ways to institutionalize the improvements. Proposals should address the utilization of the developmental disability network and resources, the Education of All Handicapped Children Act (Pub. L. 94–142), the creation of mechanisms to ensure a timely transfer of educational records including psychological and educational assessments and the Individual Education Plan (IEP) when a foster child moves from one school to another.

The applicants should propose models, resources and approaches which could be widely disseminated. Eligibility is limited to Public or voluntary child welfare agencies. Applications should list organizations, especially educational agencies and schools, that will work on the project along with a brief description of their contribution. Written assurances should be included with the application if available.

HDS anticipates funding 17 month projects having a Federal share between $75,000 to $100,000 per project.

1.2.E: Meeting the Health Care Needs of Children In Foster Care

Twenty five percent of children entering foster care are found to be below the fifth percentile in height and weight and to be suffering from a variety of medical and health problems and chronic conditions. Eighteen percent of the children are judged to have serious health problems. The 1986 study by Roger White, John Hopkins School of Hygiene and Public Health, entitled *Health Status and Utilization Patterns of Foster Care Children* describes this and other aspects of health needs of foster children in Maryland. Foster care agencies generally have some plan for providing medical and dental care, as the need arises. Too often however, insufficient attention is paid to the early comprehensive diagnosis and treatment of health problems.

HDS is interested in projects which demonstrate cost effective methods for early assessment and prompt health treatment for children in foster care. Consideration should be given to the use of Early Periodic Screening, Diagnosis and Treatment (EPSDT) services under title XIX; alternative medical care arrangements such as health maintenance organizations, involvement of parents in compiling medical history, identifying existing conditions, and assisting in providing continuity of medical care; and support and advocacy groups which address developmental needs and other health problems of children. Methods that will lead to the continued improvement of the relationship between the health care system and the child welfare system are sought.

The applicants should propose models, resources and approaches which can be widely disseminated. State and/or county child welfare agencies are eligible to apply. Applicants should list organization that will work on the project, including health care facilities, along with a brief description of their contribution. Written assurances should be included with the application if available.

HDS anticipates funding 17 month projects having a Federal share between $75,000 to $100,000 per project.

1.2.F: Training of Foster Parents to Deal with Sexually Abused Children

Increasing numbers of sexually abused children are coming to the attention of child protective service agencies. Most of the cases coming to public attention are intrafamilial or involve someone close to the family. Often, it is necessary to separate the child from the alleged or known perpetrator. Agencies may encourage the perpetrator to voluntarily leave the home while undergoing treatment; or, the court may order the removal of the perpetrator from the home rather than the child. Nevertheless, there are many instances in which the child is removed from the home and placed in foster care while the case is more fully investigated, parents undergo treatment or rehabilitation programs or legal processes ensue.

Added to the physical trauma which may have been experienced by the sexually abused child, the psychological, emotional, and personal consequences may be even more difficult for the child to bear. The child may experience feelings of victimization, confusion and guilt, and may have developed pathological and/or self defeating patterns of relating to adults and other children.

Many of these children need professional mental health services; and, foster parents and group care staff may need specialized training to develop supportive remedial relationships with these children. In addition, to helping the child deal with the traumas of victimization and separation, foster parents and group care staff must help the child rebuild his or her relationship with the natural family, and deal constructively with separation from the natural family when that is the only recourse.

The purpose of this effort is to support specialized training of foster parents and group care staff who care for sexually abused children. Project development should involve both the child protective service agency and community mental health agency to train and confer with selected group care staff and foster parents. Proposals should list the organizations that will work on the project along with a brief description of their contribution. Written assurances should be included with the application if available. Either or both agencies in combination may apply.

HDS anticipates funding 24 month projects having a Federal share not to exceed $60,000 each for the first year, and $40,000 each for the second year.

1.2.G: Improving Protective Services Administration and Performance

During 1984 approximately 1.7 million reports of child abuse and neglect were received and documented by the States and other jurisdictions. Protective services have experienced an annual increase of 11% in the number of reports during the past five years. This increase of more than 50% in the workload has affected the efficiency and effectiveness of protective services. This is due, in part, to the historical lag of several years between the increase in child maltreatment reports and the administrative and resource allocation adjustments made by State and local protective service agencies. This is evidenced by the increasing use of a triage decision process to assure protection for those children at greatest risk.

HDS will consider projects which enable agencies to develop and implement ongoing monitoring systems and identify, analyze and correct weaknesses in State, county or metropolitan area protective services systems.

Issues addressed should represent several aspects of administrative procedures including qualifications of staff, including supervisory staff; staff-supervisory ratios; effective deployment of staff from intake through service completion; and uniformity of definitions and substantiation criteria through out the agency, including counties for applicant States.

All applicants should have a plan for regular review and analysis of critical decisions, e.g., substantiation, development of case plans, provision of family based services or foster care placement, selection of treatment alternatives and return of the child to his home.

The first year should be devoted to the development and pilot testing of the quantitative performance measures and analysis of current administrative procedures. During the second year the monitoring system shall be fully implemented as an ongoing administrative process, and a formative assessment shall be conducted after two quarters' experience to examine the impact on the administrative decision process. Implementation of revised procedures and programs should be projected by the end of the second year.

HDS anticipates funding 24 month projects having a Federal share ranging from $75,000 to $100,000 per project, per year. Eligibility is limited to States, counties or large urban or metropolitan agencies that annually receive 30,000 or more maltreatment reports.

1.2.H: Partnerships of Unions, Sororities, Fraternities, Service Organizations and Indian Organizations with Social Service Agencies in Support of Special Needs Adoption

During the past three years, several organizations received Federal grants to develop public/private cooperative efforts to increase public awareness and facilitate the adoption of special needs children. Children were featured in company newsletters, on posters and flyers in office buildings and other worksites. Their plight was presented at business meetings, churches, conferences and other special events. In addition, adoption benefits packages were developed to be used by corporations and manuals were developed to be used by various adoption groups and organizations interested in working with the corporate sector.

Over 40 companies provide employees with benefits to help them adopt children. An increasing number of companies and groups are using this approach as an opportunity to support their employees' interest in adoption.

HDS seeks to develop similar efforts through a collaboration between public and voluntary social service agencies and unions, fraternal groups, service organizations or Indian organizations.

Proposals should include strategies which involve the union, fraternity, sorority, service organization or Indian organization in the adoption of special needs children. Such strategies may include:

- Providing special needs adoption information and education through presentation at forums, national conventions and conferences of these groups;
- Utilizing media in featuring children such as in "Wednesday's Child" television programs and newspaper columns;
- Developing or replicating programs for recruiting members of these groups as adoptive parents and for utilizing members as recruiters;
- Developing an adoption benefit plan for members/staff of these groups who adopt special needs children.

Eligible applicants are public or voluntary social service agencies, unions, sororities, fraternal groups, service organizations and national Indian organizations. Demonstration projects should represent new efforts to promote special needs adoption. Applicants should list organizations that will work on the project along with a brief description of their contribution. Written assurances should be included with the application if available.

HDS anticipates funding 17 month projects having a Federal share not to exceed $35,000 per project.

1.2.I: Effective Strategies for Adoption Opportunities for Children in Residential/Group Care

Children with developmental disabilities, emotional and behavioral problems who reside in group care facilities may not have an opportunity for adoption. Adoption is not systematically considered as an option for these children when they cannot be reunited with their families. As a result, some of these children age out of the system without being considered for adoption. Often the staff in residential or group care facilities are not knowledgeble about adoption services and adoption opportunities for the children in their care. They may also be skeptical because some of these children have already experienced adoption disruption or dissolution.

The purpose of this priority area is to demonstrate that adoption is a viable alternative for certain children in residential/group care. Applicants should be prepared to develop effective methods for preparing children in residential/group care for adoptive placement and coordinate or provide post placement/post finalization services to prevent adoption disruptions.

HDS will consider model approaches for child placing agencies working with residential/group facilities, and residential/group facilities providing their own child placing services.

Each project should develop materials suitable for national dissemination. The applicant should target a specific number of children to be placed in adoptive families (a minimum of twenty-five children per project is suggested) as a result of the project and describe any extraordinary social or community involvement.

Eligible applicants include public or private non-profit child care institutions and other child welfare service agencies.

HDS anticipates funding 24 month projects having a Federal share not to exceed $75,000 per project, per year.

1.2.J: Coordination of Court Actions in Child Abuse and Neglect Cases

Abused and neglected children and their families are often involved in court proceedings which have a significant impact upon their lives. The court proceedings may be held in Juvenile Court, Domestic Relations Court, or Criminal Court.

Frequently, families may be involved with several of these courts at the same time with each court acting independently of the other. In such instances there is always the potential for confusion, overlap, duplication of effort and court dispositions which do not take into account the impact of other court actions. Stress is increased for families involved in multiple court actions and this creates a need for: (1) Coordinated court proceedings; (2) expedited court processes and; (3) where possible, consolidation of cases.

Child Protective Services (CPS) agencies frequently conduct investigations of reported child abuse or neglect prior to court hearings; or, at the request of the court, make an investigation if there was no prior involvement of CPS. Coordination of effort is needed between the courts, their investigative staff, the prosecutor's office, and the Child Protective Services Agency.

Consideration will be given to proposals which develop and implement appropriate procedures, including court rules, for the coordination of efforts and expedited processes. Through such measures, overlapping and duplication of effort will be reduced or eliminated at a savings to the State and community, and the trauma experienced by the child and family will be reduced.

Applicants should list organizations that will work on the project, including the courts of jurisdiction and the prosecutor's office, along with a brief description of their contribution, particularly as it relates to coordination with the Child Protective Services Agency. Written assurances should be included with the application if available. Courts are encouraged to apply.

HDS anticipates funding 24 month projects having a Federal share not to exceed $50,000 per project, per year.

1.2.K: Improving Child Protective Services on Indian Reservations

In an effort to protect children from abuse and neglect on reservations, some Indian Tribes have taken steps to develop a protective services system within their child welfare services. Other Tribes have developed Tribal/State agreements that describe which services will be provided by the State agencies and which will be provided by the Tribe. Nevertheless, protective services for Indian children living on reservations are often fragmented for a variety of reasons, including lack of clarity about program responsibility among the various service providers, absence of an identified central location for receiving reports and developing a coordinated service response, conflicting legal and jurisdictional issues, geographic isolation, unavailability of multidisciplinary child protection teams and other skilled professionals.

The purpose of this priority area is to assist Tribes to improve their protective services for Indian children on reservations. HDS is interested in supporting several projects which will develop and implement a comprehensive service system. Project activities may include the development of Tribal/State agreements; interagency agreements for service coordination among Tribal agencies (e.g., Indian Health Service, Tribal law enforcement, courts and social service agencies); establishment of a central point for receiving and responding to reports of child abuse and neglect; establishment and maintenance of a central registry for record keeping on reports and substantiated cases; development of policies and procedures for investigation, risk assessment and family intervention; implementation of multidisciplinary child protection teams and development of child abuse prevention activities.

Proposals should describe the current protective service system and specific goals and objectives to be carried out over a 36 month period. Outcomes should be measurable and stated clearly and progress should be documented at the end of each year's activity.

HDS anticipates funding 36 month projects having a Federal share ranging

from $50,000 to $85,000 per project, per year.

1.2.L: Improvement of State Child Welfare Licensing Programs

Services for most of the children in the child welfare system are impacted by State licensing. Licensing is one of the States' major mechanisms for protecting children who are not with their families, and to mandate a basic level of quality service consistent with current practices. Licensed services include placement of children into adoptive and foster homes, and care received in family foster homes, child care institutions, family day care and day care centers. State licensing is beginning to include services such as day treatment and independent living.

A large number of children are affected by licensing including virtually all the 276,000 children in foster homes and institutions. It also includes millions of children in licensed family day care and day care centers.

In 1983 HDS supported development of model State licensing materials. Nearly all States have utilized some aspects of this material. However, efforts to adapt licensing to the growing need to prevent abuse, and to new kinds of service such as day treatment, drug treatment, specialized family foster care and independent living have not kept pace with practice and need. Many States have acted to apply licensing requirements to services provided by public agencies, however, the majority of such services, particularly public child placing agencies, are still unlicensed.

HDS will consider applications to enable States to improve existing licensing programs and to extend the protections to services not yet covered.

Project activities could include amending licensing laws, licensure of public agencies and new kinds of services, organizational change, development of standing advisory committees or boards, revision of licensing rules and development of accompanying policy and training to implement such changes.

Fifteen states have already received grants to improve licensing programs. Eligibility is limited to those States which did not receive licensing improvement grants in Fiscal Years 1984 and 1985.

HDS anticipates funding 17 month projects having a Federal share not to exceed $30,000 per project.

1.2.M: Adoption Opportunities for Older Children

Many children who are legally free for adoption are over the age of 12, and remain in foster care because they are perceived as being "unadoptable". These children may be handicapped, or have school and learning problems, or exhibit behavioral difficulties in addition to being older. Because of feelings for their natural family or in order to protect against hurt and disappointment, some of these children also declare that they do not want to be adopted. The home finding for these children and the preparation of both the older child and the family for adoption requires skill, determination and a belief that all children deserve a permanent home. With adequate assessment and extensive preparation, many older children can be successfully placed for adoption.

As adoption of older children is a relatively new phenomenon, agencies need to examine their attitudes with regard to adoption of the older child. Workers need encouragement, time, skill development and on-going agency support to effectively plan and implement placement decisions. Effective recruitment, skillful preparation of adoptive parents and post-placement counseling for the older child and his adoptive family are also needed.

HDS will consider projects which develop and demonstrate specific methods for increasing older child adoption and delivery of post placement services to prevent disruption. In addition, suitable materials must be prepared for dissemination.

HDS anticipates funding 24 month projects having a Federal share not to exceed $75,000 per project, per year.

1.2.N: Strategies for Recruitment and Retention of Foster Families

Currently the public child welfare system serves about 276,000 foster children in 100,000 foster family homes. About 23% of the children are classified as having special needs. Almost half are over age 13 and over 50% of these youth have been in more than one placement. Workers and administrators report that many of these children have multiple problems and are increasingly difficult to care for. As a result, there is frequent turnover among foster parents and replacement of children into different foster or residential settings.

HDS is interested in proposals which demonstrate a set of cost effective recruitment, training and support strategies which address the community's foster care population. Consideration should be given to including foster care workers and supervisors, in addition to foster parents, in the training; to providing a variety of support strategies such as training, respite care, cluster homes or other innovative forms of mutual support; and to coordinating with appropriate parental support and advocacy organizations which serve specialized or developmentally disabled populations, (e.g., Association for Retarded Citizens, Association for Children with Learning Disabilities, etc.). Funds should not be used to develop new training materials, unless there is a clearly documented need in the proposal itself.

HDS anticipates funding 17 month projects having a Federal share not to exceed $100,000 per project.

1.2.O: Prevention of Abuse and Neglect in Infants of Chemically Dependent Mothers

Increasing numbers of infants are at risk of prenatal and postnatal neglect or abuse resulting from parental abuses of substances, including drugs and alcohol. These children may be born drug addicted; evidencing exposure to the AIDS virus; suffering from fetal alcohol syndrome; and lacking in age appropriate neurological development, resulting in symptoms such as hyper-irritability, gastrointestinal dysfunction, respiratory distress, fever, high-pitched cry, uncoordinated or undeveloped sucking and swallowing reflexes, dehydration, and other related symptoms. Many are of low birth weight, one of the most relevant predictors of infant mortality. Studies comparing the use of drugs and alcohol of mothers and their babies to non-users have demonstrated the deleterious effects of substance abuse on newborn infants.

According to Congressional hearings held in May 1986, hospitals are reporting startling increases in the number of babies born physically and mentally damaged from the mother's use of PCP, cocaine and other substances, including alcohol. For example, in New York City, the number of addicted births rose from 227 or 1.5 of each 1,000 live births in 1966 to 884 or nearly 8 of each 1,000 live births in 1983.

The Center for Disease Control reported that of 281 cases of AIDS in children under 13 years of age as of April 1986, 75% of the children contracted the disease from their mothers either during pregnancy, or immediately after birth. Of those, 61% of the mothers were drug users themselves and 12% had drug using male sex partners.

The social costs for neonatal care, and subsequent care for these children are great. The personal loss for these children is inestimable. Many are subjected to repeated abuse or neglect by parents who continue to be dependent on drugs or alcohol or who are unable to deal with the difficulties

presented by their special needs offspring. Still other children leave the hospital for out-of-home placements with foster parents who are unprepared for the specialized care which these infants require.

The purpose of this priority area is to develop demonstration projects which reduce the risk of abuse or neglect for infants born to chemically dependent mothers.

Applications must include a well developed, systematic plan that identifies and provides comprehensive services to chemically dependent mothers during pregnancy and until the end of the child's second year, that assesses the progress of the child's development and of the parent/child relationship, and that includes an evaluation component that is integrated into the program design. Application should list organization that will work on the project, especially health, mental health and social service providers, along with a brief description of their contribution. Applicants should also describe any extraordinary social or community involvement in the project. Written assurances should be included with the application if available.

Programs may be based in hospitals, mental health facilities, state county or urban public or private social service agencies and may include, but are not necessarily limited to, drug and alcohol abuse rehabilitation programs, nurse or lay home visitor programs, or specialized foster care programs.

HDS anticipates funding 36 month projects having a Federal share not to exceed $100,000 per project, per year.

Topic 3: Improvement in Community Systems for Responding to the Needs of the Elderly

Introduction

Because of the rapidly growing number of older persons in our society and the complex and often fragmented nature of current service delivery systems, communities are being challenged to "rationalize" their service systems and to make them more responsive to the needs of the elderly, particularly those who are most vulnerable. State and Area Agencies on Aging, Indian tribal organizations—as well as many other public, private and voluntary organizations—are faced with the need to assess the adequacy of existing service arrangements and to implement more effective systems for the provision of family and community-based care.

States and communities are being called upon to develop service systems that are significantly more accessible, that provide a continuum of services in a timely fashion, and that demonstrate effective linkages and collaboration among the many community-level organizations affecting the lives of the elderly. Also of concern is the need for improved response capability for crisis intervention in times of emergency, for the establishment of highly visible information, outreach and follow-up services, and for special efforts to serve those older persons and families who are most vulnerable to loss of independence.

The priority areas under this topic are intended to encourage State and Area Agencies on Aging, Indian tribal organizations funded under Title VI of the Older Americans Act, as well as other organizations with an interest in the elderly, to develop innovative project proposals which will significantly improve community-level service systems as suggested above. *A community is a place where older persons live and secure, as needed, appropriate services and care. In most cases, this is a geographic unit smaller than a Planning and Service Area.* The specific priority areas under this topic follow:

1.3.A: Assessments of Community Service Systems and the Roles of Area Agencies on Aging (AAA's)

The 1978 Amendments to the Older Americans Act charge AAA's with responsibility for helping to ensure development of "comprehensive and coordinated" service systems for older persons. In response to this mandate, AoA provided financial support to an organization called The Assistance Group for Human Services Development for the purpose of developing technical assistance material to help AAA's fulfill this important mission. This project resulted in the preparation of a two volume publication entitled, *Developing Comprehensive and Coordinated Service Systems for Older People: An Area Agency Guide.* The purpose of the *Guide,* which originally became available in November, 1981, is to help AAA's, local policy-makers, and others in the community to:

- Understand the meaning and characteristics of comprehensive, coordinated service systems;
- Assess local systems and define what can and should be done to improve them; and
- Select and implement strategies for system development.

Volume I of the *Guide* gives a brief overview of comprehensive and coordinated service systems, discusses the interacting parts of service systems for the elderly and gives examples of roles that AAA's might play in improving local systems. It also poses a series of preliminary questions for an AAA to use in assessing its own understanding of local systems and evaluating a community's readiness to strengthen the service system.

Volume II consists of more detailed "indicator" questions for AAA's to use in gauging the current status of their communities' system of services and in assessing the AAA's role in developing those systems. This part of the *Guide* is designed to help an AAA determine if all the elements of a comprehensive family and community-based care system are in place, and if the elements are adequate and properly linked together. The purpose is to help AAA's identify specific opportunities for improvement and to give the AAA an overall framework for setting priorities for action.

AoA solicits applications from State Agencies on Aging for the conduct of demonstrations within the State designed to assess existing systems of family and community-based care for the elderly and to assess the roles of AAAs in helping to develop these systems.

Proposed demonstrations should:

(1) Be organized and supervised by a State Agency on Aging;

(2) Involve 4 to 6 different communities within a State as part of a controlled multi-site demonstration;

(3) Utilize the Assistance Group's instrument referenced above or another already-developed instrument suitable for assessing community-level service systems and the roles of AAA's;

(4) Involve the application of the assessment instrument by the participating AAA's within the communities selected for the demonstration; and

(5) Result in across-site analyses of findings by the State Agencies on Aging participating in the demonstration, including analyses pertinent to improving the assessment instruments employed.

AoA's purposes in soliciting these demonstration projects are several:

(1) To gain information on the practical experience of AAA's in their application of community assessment instruments in sites across a number of States. This includes information on the extent to which the *Guide* or other instrument enables AAA's to identify community service system weaknesses and to set specific priorities for action;

(2) To analyze the utility of the *Guide* or other instrument for establishing baseline information both with respect to the current services system in each participating community, and with

respect to the activities of the AAA's involved;

(3) To encourage State Agencies on Aging to consider future use of the *Guide* or other appropriate assessment instrument by AAA's on a Statewide basis; and

(4) To identify any modifications to the *Guide* or other existing instrument that might be useful to make in order to improve their utility and practicability for wider-scale use in the future.

Applications in this priority area must identify all proposed demonstration site communities. Applications should list all AAAs and other organizations that will collaborate on the project and describe the nature and extent of their collaboration. Written assurances should be included with the application if available. The applicant's proposal must address how the demonstration will be organized and executed across all sites; how results will be documented, analyzed and reported; and what training and technical support will be provided to the participating AAA's.

Applicants wishing to use an assessment instrument other than the *Guide* developed by the Assistance Group must submit a copy of the proposed instrument as part of their applications. Copies of the Assistance Group's instrument, *Developing Comprehensive and Coordinated Service Systems: An Area Agency Guide,* may be obtained by writing to the Administration on Aging, Division of Research and Demonstrations, Room 4265, 330 Independence Avenue, SW., Washington, DC 20201, Attention: Dr. Harry Posman.

Federal funding for projects in this priority area is limited to $250,000 for a maximum duration of 17 months. Eligibility is restricted to State Agencies on Aging.

1.3.B: Aging Network Linkages—Improving Linkages Between the Community Health Care System, Especially Hospitals and Community Health Centers, and the Community Supportive Service System

In our society, many agencies—public, private and voluntary—share responsibility for serving the elderly population. Each constitutes a potentially important element in the creation and maintenance of what the Older American's Act terms a "comprehensive and coordinated service system." State and Area Agencies on Aging have a special, legislatively mandated responsibility to identify gaps and to serve as brokers and catalysts in helping to develop integrated service approaches.

The purpose of this priority area and the three that follow is to stimulate demonstrations involving creative linkages between State and Area Agencies on Aging on the one hand and other organizations that can play useful roles in improving service systems and access to services at the community level.

The intent of this priority area is to demonstrate how State and Area Agencies on Aging can work with hospitals and community health centers to more effectively plan and integrate health and supportive services for the elderly. Major changes are occurring in the health care system. In many communities the hospital is evolving as the core of the community health system providing, in addition to traditional institutional and out-patient services, health services in satellite clinics and hospital-based in-home services. Likewise, community health centers, traditionally focused on maternal and child-care, may become a primary health care resource to increasing numbers of elderly persons.

As brokers and catalysts for improved community service systems, Area Agencies on Aging (AAA's) can help insure that there are effective linkages between community-based agencies providing supportive services on the one hand, and community health centers and the hospital-based health care system on the other. AAA's should provide leadership in the planning and implementation of responsive community systems which provide for a continuum of care between hospital-based services and the services required in the less restrictive environment of home and community.

Applications are solicited from AAA's to work collaboratively with the administration of hospitals and community health clinics to plan and implement more effective linkages between the health care and supportive services systems for older persons in selected communities. Applications should provide written evidence of commitment on the part of the participating hospital(s) and health clinic(s) to collaborate closely with the AAA in both planning and implementation of an improved continuum of community care for older persons.

Applications are also solicited from State Agencies on Aging to develop collaborative State-level activities that will effectively link the health care and supportive services systems at the community level. Projects should not be focused primarily on planning; rather they should emphasize the implementation of concrete actions that will result in improved linkage between the two service systems on either a Statewide basis or in selected geographical areas. Applications should list all the organizations that will collaborate on the project, including the responsible State Health Agency, as well as the affected Area Agencies on Aging, hospitals, health clinics and other appropriate agencies, and describe the nature and extent of their collaboration. Written assurances should be included with the application if available.

All applications in this priority area must include an implementation plan and specify measurable outcomes. Applicant State or Area Agencies on Aging may not provide direct services themselves as part of any project proposed under this priority area.

Federal funding for projects in this priority area is limited to $150,000 for a maximum duration of 17 months. Eligibility is restricted to State and Area Agencies on Aging.

1.3.C: Aging Network Linkages—Increasing State Agency on Aging Leadership Capacity to Assist Alzheimer's Disease Victims and their Families

Many State Agencies on Aging have identified Alzheimer's Disease as a growing area of concern warranting additional effort and attention within their States. While considerable progress is being made, many State Agencies are hampered by difficulties in obtaining necessary technical support and expert training for organizations and agencies serving persons afflicted with this condition. In order to address this need, AoA invites applications involving collaborative capacity-building efforts between State Agencies on Aging and organizations with recognized expertise in Alzheimer's disease. Specifically, AoA is soliciting applications involving projects jointly planned and executed by State Agencies on Aging and either the Long Term Care Gerontology Centers, the National Institute on Aging's Alzheimer's Disease Research Centers, or other organizations qualified to assist State Agencies in their efforts to improve family and community-based care for victims of this disease. Project proposals might address any of several capacity-building activities including, for example, State Agency on Aging collaboration with such organizations to:

(1) Provide information and training to professional and paraprofessional staff of community service agencies dealing with Alzheimer's disease; or

(2) Design and carry out model projects that demonstrate innovative approaches in the provision of services

such as respite care, crisis intervention, day care, or other supportive service programs.

In addition to collaboration with the organizations identified above, State agency proposals should show the involvement of the Alzheimer's Disease and Related Disorders Association at either the national, regional or State chapter levels.

All applications should include a working agreement between the State Agency and the other participating organizations that clearly describes the role of each agency in carrying out the proposed project and the tasks that each will undertake.

State Agencies on Aging which are not familiar with the National Institute on Aging's Alzheimer's Disease Research Centers may obtain information about them by writing to: Administration on Aging, Division of Research and Demonstrations, Room 4265, 330 Independence Avenue, SW., Washington, DC 20201, Attention: Dr. Harry Posman.

Federal funding for projects in this priority area is limited to $150,000 each year for a maximum of 2 years. Eligibility is restricted to State Agencies on Aging.

1.3.D: Aging Network Linkages—Improvement in Emergency Services

There are many communities that do not have an adequate response capability to meet the needs of older persons and their families in times of crisis or emergency. This may be due to a lack of services; failure to coordinate existing services; or poor dissemination of information.

This priority area is intended to stimulate proposals which demonstrate collaborative efforts between Area Agencies on Aging (AAA's) or Indian tribal organizations funded under Title VI of the Older Americans Act and other organizations that result in the implementation of 24 hour-per-day, 7 day-per-week emergency response capability.

Proposals along these lines should involve the relevant community agencies (AAA's, Title VI Indian tribal organizations, information and referral services, police and fire departments, hospitals, shelters, utility companies, etc.) and may address such needs as improved emergency referral and communications networks, training of personnel, the establishment of "hot lines," etc. In addition to older persons themselves, the target population for proposed activities should include special and innovative efforts to provide information to family members, caregivers, friends, neighbors and the general public, who may need to help older persons access services. Evaluation of overall effectiveness and cost should be an integral part of all projects in this area.

Applications should describe how the proposed project will have a continuing significant impact on the problems being addressed.

Federal funding for projects in this priority area is limited to $150,000 for a maximum of 17 months.

1.3.E: Aging Network Linkages—Improving Linkages with Long Term Care Facilities

Nursing homes, board and care facilities, congregate housing complexes, group homes and other non-medical residential facilities are a critical part of the community-level continuum of care to help older people. While most older persons are able to live independently with help from family and friends, some require the kind of assistance provided in group or institutional settings on a temporary or permanent basis. As leaders in developing community responses to the needs of older people, Area Agencies on Aging must work closely with these community-level residential long term care resources.

Applications are solicited from Area Agencies on Aging, from organizations providing residential long term care and any other organizations concerned with older persons for collaborative efforts to plan and implement projects that will assist communities in developing a continuum of care for meeting the needs of the vulnerable elderly. Project proposals must focus on establishing more effective linkages and collaborative programming between supportive services and residential long term care available in local communities. Proposals may address any of several priority concerns, including:

(1) Development of community systems to assure appropriate placements for older persons needing some form of residential living arrangement;

(2) Activities designed to upgrade the quality of life for older persons living in residential long term care facilities;

(3) Efforts intended to assist elderly persons and their families in making transitions from one living arrangement to another, e.g., from hospital to congregate housing or from nursing home to the older person's own home; and

(4) Projects involving collaborative programing to establish systems for the provision of supportive services for older persons living in congregate housing complexes, board and care homes, and other residential long term care settings.

Applications should list all the organizations that will collaborate on the project and describe the nature and extent of their collaboration. Written assurances should be included with the application if available. In addition, applications from organizations other than Area Agencies on Aging must intimately involve the local Area Agency as a key actor in the design and conduct of the proposed project. All project proposals must set forth the measurable outcomes expected. Applications should describe how the proposed project will have a continuing significant impact on the problems being addressed.

Area Agencies on Aging may not provide direct services themselves as part of any project proposed under this priority area.

Federal funding for projects in this priority area is limited to $150,000 for a maximum duration of 17 months.

1.3.F: Improving Targeting of Services to the Vulnerable Elderly

This priority area addresses efforts that might be undertaken to further improve the aging services network's capability to ensure that services are provided to those who may need them most but who, for a variety of reasons, are less likely to be served than the general aging population. It is intended to stimulate demonstrations of ways to reach and serve more effectively those older individuals and families which, in the words of the Older Americans Act, have the "greatest social or economic needs." The specific target population for this priority area is functionally impaired older persons who have significant difficulties in accessing the services they require to remain in their own homes and who are in danger of institutionalization.

Applications are invited from State and Area Agencies on Aging, Indian tribal organizations funded under Title VI of the Older Americans Act, as well as from other appropriate organizations, for demonstration efforts intended to mobilize community resources in order to provide a continuum of care for vulnerable older persons. Barriers to service access which may be addressed by project proposals may encompass, but are not limited to, inability to leave the home because of handicap, developmental disability or other functional impairment, isolation or rural living environment, lack of familiarity with the formal social service system, and language or cultural barriers which may be associated with being a member of a minority group.

Projects in this priority area are expected to involve a high degree of

collaboration among State and/or local agencies and to focus existing community resources on activities intended to enable the vulnerable elderly to remain in their homes and to live as independently as possible.

Applications should show significant potential for making measurable progress in assisting this target population, and describe how the proposed project will have a continuing significant impact on the problems being addressed. Proposals from organizations other than State or Area Agencies on Aging, or Title VI Indian tribal organizations should provide for substantial involvement of these agencies.

Federal funding for projects in this area is limited to $200,000 for a maximum of 17 months.

1.3.G: Hospital Emergency Services—Tapping Their Full Potential for Older Persons

Each community should have a continuum of care for the elderly that brings together an effective and appropriate mix of family, community, and institutional resources. Among these resources is the hospital emergency room service. The emergency room is not only an immediate source of primary medical care for a large percentage of older people, it is also a major point of referral, access, and disposition into the extended network of health and related supportive services. As a gatekeeper to the health care system, the emergency room can serve an important role in coordinating and linking elements of the continuum of care to enable clients to stay out of institutions and in family/community settings whenever possible.

Demonstration project proposals are invited to test the feasibility and efficacy of this role wherein hospital emergency service facilities are linked formally and systematically with Area Agencies on Aging in the coordination of a continuum of care for elderly persons. These model demonstration projects should be based on an assessment of the relationships between agencies providing emergency services, health and supportive services, and should focus on improving system linkages and on how professional service providers in these organizations are utilized. The models may also address themselves to the resolution of linkage problems in such areas as transportation, insurance, information and referral, and case management.

Project proposals should involve multiple hospital emergency service facilities within the community or communities selected as demonstration sites. In addition, because of Area Agency on Aging responsibility for developing and maintaining family and community-based systems of care for older persons, applications should provide evidence of direct involvement of these agencies in the design and implementation of project proposals. However, Area Agencies on Aging may not provide direct services themselves as part of any project proposed under this priority area.

Federal funding for projects in this area is limited to $175,000 per year for a maximum duration of 17 months.

1.3.H: Field-Initiated Proposals for Improving Community Service Systems for the Elderly

This priority area allows for the submission of project proposals intended to effect significant improvements in community-wide service systems *which are not addressed elsewhere in this Announcement.* It provides State and Area Agencies on Aging, Indian tribal organizations funded under Title VI of the Older Americans Act and other organizations serving the elderly with an opportunity to present innovative ideas for improving community-level service systems not stated elsewhere in this Announcement.

Only a few extremely high quality projects are likely to be supported. HDS will consider applications which:

(1) Propose major redirections of effort on the part of State or Area Agencies on Aging or Title VI Indian tribal organizations, including but not limited to, redirection of Title III resources to effect systemic improvements in aging services at State or local levels;

(2) Propose major new mobilizations of private and voluntary sector organizations for the purpose of rationally coordinating existing service resources and capabilities, and improving the integration of fragmented service delivery systems;

(3) Support broadscale State-level or Indian reservation-level analyses and implementation of policies, procedures and organizational arrangements designed to improve programming for the elderly; or

(4) Involve the implementation of significant new State-wide, metropolitan area-wide, county-wide or reservation-wide priorities for services to the elderly and their families.

Proposals should show active support and involvement on the part of State and local elected officials and relevant State and local agencies impacting the elderly.

Awards under this priority area will not be made:

(1) For proposals which are essentially covered by other priority areas in this announcement;

(2) For projects limited primarily to planning;

(3) For Federal support for new services or the extension of existing services;

(4) For case management or services directly provided by staff of an Area Agency on Aging;

(5) For building construction or renovation; and

(6) For activities which can reasonably be expected to be implemented with existing Title III, Title VI or other available resources.

Proposed projects may not exceed a maximum duration of 24 months. Notwithstanding the ceiling on project costs stated elsewhere in this announcement, applicants under this priority area may apply for an annual level of funding commensurate with the scope of work of the proposed project.

Section 2: Economic and Social Self-Sufficiency

Topic 1: Individual Self-Sufficiency:

2.1.A: Expanding Employment Activities for Persons with Developmental Disabilities

In November 1983, President Reagan made a major step towards improving the employment options for persons with developmental disabilities by signing into effect an Employment Initiative for Persons with Developmental Disabilities. This new initiative involved developing employment opportunities in the competitive employment sector through pledges and other job commitments from private employers. In the period since the signing of this important proclamation, more than 87,000 persons with developmental disabilities have been placed in jobs in the integrated, competitive labor market.

The economic side effects have been impressive: the 87,000 newly employed workers will earn about $400 million in gross annual *taxable* wages, while the combined savings in public support costs and services will approximate another $400 million.

While we will continue to expand employment opportunities for adults with developmental disabilities leaving sheltered employment, the need in FY 1987 is for demonstration projects that target the youth population exiting the school system and facilitate the transition from school to work.

The U.S. Office of Special Education and Rehabilitative Services (OSERS) estimates that 250,000 to 300,000 students with handicaps leave special

education each year. Youth with disabilities, such as mental retardation, physical disabilities, and other disabilities have obstacles that make the transition from school to employment a difficult achievement. It is estimated that between 50 to 75% of young adults with disabilities are jobless. A majority of these are students who need additional help through educational training and rehabilitation services and programs in order to be able to make the transition from school to competitive employment. Unfortunately, many of these students will not make any major gains in the world of work unless there are early coordinated efforts to identify and develop strategies that will lead to a range of employment possibilities.

Much of the focus in the past few years has been on the development of supported employment options for persons with severe disabilities. This option has shown that given sufficient support, many adults with severe disability can work in real work settings. Achievements in accessing real work settings have further supported the commitment of HDS to a range of employment possibilities as appropriate options for persons with developmental disabilities. In one instance, the passage of a statewide transition law necessitated the creation of a tracking system for special needs high school graduates. Data from that system show that more than 80% of those expected to graduate in the next two years will face sheltered employment as the only job possibility. These data are a reflection of the data being reported by many other States.

Though technology is available to assist persons with severe disability in entering employment in real work settings, this technology requires human service personnel with an orientation to industry and an ability to relate not only to client needs but industry expectation.

HDS is interested in demonstration projects that support the goal of youth economic self-sufficiency and which address the following priority areas:

- Strategies to provide students with meaningful paid work opportunities while still in school. These work opportunities may begin as early as age 14 and are intended to give students with disabilities the same work experiences as other students and to instill positive attitudes toward work. Responsibility for developing these work experiences should be shared among the local vocational and special educational programs, industry, and accomplished in consultation with vocational rehabilitation. Development of a set of youth competencies for finding, obtaining and keeping a job, in partnership with local PICs, is encouraged.
- Projects at the State and local levels to develop alternative reimbursement strategies which serve as barriers to transitional services. Obstacles identified which impede or prohibit the provision of employment of community-based services are: (1) The inability of service agencies to "pool" funds and/or other resources, and (2) lack of appropriate residential and/or transportation alternatives.
- Projects which expand the corporate base of support for opening up jobs in new industries for students exiting school and transitioning into employment. To date, industries supporting employment of persons with developmental disabilities include food services, horticulture, hospitality, hospitals, housekeeping and grounds and building maintenance.

HDS is interested in projects designed to promote the employment of persons with developmental disabilities by addressing clearly identified needs. Cost-effective, innovative methods should be identified which will have a continuing significant impact on the problems being addressed.

In addition to incorporating an appropriate role for private sector involvement, proposals addressing this priority area should also feature the following components: interagency collaboration (including, but not limited to, State and local agencies, Developmental Disabilities Councils, Protection and Advocacy agencies, JTPA, Private Industry Councils, University Affiliated Facilities and parent groups); discussion of how the proposed work will both interface with and depart from current employment projects underway within the State; and development of well-conceived strategies for dissemination and utilization. To that end, a list of projects recently funded by HDS on the topic of employment for persons with developmental disabilities can be obtained by writing: HDS/Division of Research and Demonstration, Room 724F, 200 Independence Avenue, SW., Washington, DC 20201 telephone (202) 755–4633.

Under this priority area, HDS plans to engage in cooperative activities with agencies including, but not limited to, the Rehabilitation Services Administration, Office of Special Education and Rehabilitative Services, Department of Education, and the Employment and Training Administration, Department of Labor. Federal funding for projects in this priority area is limited to $100,000 per year with project periods not to exceed two years. Applicants are restricted to public or non-profit private entities in this priority area.

2.1.B: Innovative Community Approaches to Entrepreneurial Activity with Native American High School Youth

It is widely recognized that persons who do not complete school experience self-image problems arising from unemployment and the absence of skills needed to do a job. The decline of self-esteem accompanying this type of experience further strengthens unproductive life-styles.

The challenge of ensuring a positive life-style among youth faces all Americans. Within Native American communities, this challenge is stronger because of many factors contributing to higher unemployment, lower income, and higher incidence of health and social problems such as substance abuse and suicide among Native Americans. Since more than one out of three Native Americans is under the age of twenty, the significance of such factors is intensified in Native American communities. Yet, numerous studies have shown that strong links to a tribal heritage and educational reinforcement with Indian values are significant in maintaining self-esteem among Indian youth.

Native American youth frequently deal with experiences of isolation and anomie arising from the systems through which education is provided. Two major systemic difficulties are:

1. A significant proportion of Indian students are educated at boarding schools. According to a 1980 study by the National Indian Training and Research Center, over 20,000 Indian children live in boarding schools and dormitories, spending nine months each year separated from family and own tribe.

2. Among Indian students participating in public school systems, feelings of isolation and low self-esteem are promoted by their minority status and the absence of culture-sensitive services which deal with Indians as members of a special group with an honored heritage. Evidence of insensitivity to Indianness in school curricula is frequent, and failure to "connect" with Indian children and youth is a common occurrence.

The challenge of building self-esteem and developing skills useful for successful adult living among youth is not being met within all Native American communities striving to fulfill goals of self-determination and self-sufficiency. The social and economic development strategies (SEDS) policy

followed by the Administration for Native Americans is one element in the striving for improved well-being within Native American communities. During the four years of SEDS implementation, the Administration for Native Americans has repeatedly encountered the need for increased entrepreneurial and management know-how among Indian communities committed to goals of self-sufficiency.

At the same time, experience within the general population has shown that entrepreneurial and management skills may be readily developed among high school youth through groups devoted to the achievement of specific business objectives. Under the guidance of sensitive and experienced counselors, youth have established and operated successful enterprises.

The increased sense of belonging, as well as the transmission of work-related skills, are seen as forces which may have a substantial impact on Native American high school students. The primary purpose of this priority area is the enrichment associated with the operation of a formal program through which both the specific Native American values of the students' heritage and work-related skills are transmitted in the classroom and through extra-curricular activities geared to business operations. Such programs could both prevent negative social behavior and provide for skills acquisition not only for the youth themselves but also for the community's need for persons with entreprenuerial orientations and management skills.

Applications are solicited from American Indian Tribes, Alaskan Native Villages, Hawaiian Native groups and other Native American organizations for demonstrations promoting entrepreneurship among Native American high school students. HDS will consider demonstrations which integrate specific Native American values and culture into activities associated with the school setting. These activities should include the expectation that income producing enterprises will develop through the activity. Expected outcomes may include the development of a service needed by the educational institution, co-ops providing for the needs of the participants, and/or individual or group-managed businesses for which markets may be identified.

Applicants are encouraged to include participation by the general public and private agencies, enterprises and organizations. These may consist of partnerships with private sector enterprises, social services agencies and training and employment programs available under the Job Training and Partnership Act (through Private Industry Councils or JTPA Advisory Boards) as well as other specific local area programs.

All applications in this priority area should include an implementation plan and specify measurable outcomes such as a decline in the rates of school drop-out and substance abuse, improved self-image, or increased competency in employment-related skills among the population served. Projects may deal with boarding schools, public schools or day schools on Indian reservations.

Applicants who wish to do so may discuss this priority area with the endorsing organizations, the National Alliance of Business and the National Association of Private Industry Councils. Requests for funding may be for a maximum of three years and should include a budget for each year for which Federal funding is requested. Proposals should show that the proposed effort will have a continuing significant impact on the problems being addressed. Applications should list the organizations that will work on the project along with a brief description of their contribution. Written assurances should be included with the application if available.

2.1.C: Legal Assistance for Older Persons

Many older persons who need legal assistance find it difficult to obtain the services they require because of financial constraints, lack of familiarity with available services or reluctance to ask for help. State and Area Agencies on Aging are responsible for coordinating programs developed by local legal assistance providers that give legal advice, consultation and related services to older persons. To assist the network of State and Area Agencies on Aging in carrying out this responsibility, the Administration on Aging solicits applications from national legal assistance organizations experienced in providing support, on a nationwide basis, to local legal assistance providers.

Applications must include plans for enhancing the availability of legal services to older persons in close coordination with the programs provided by State and Area Agencies on Aging. Legal assistance support activities include, but are not limited to: Case consultation; mediation; training; provision of substantive legal advice and assistance; and assistance in the design, implementation and administration of legal assistance delivery systems to local providers of legal assistance for older individuals.

In addition to proposals from national legal service organizations, applications are also solicited from other qualified agencies that demonstrate innovative and effective ways to work with State and Area Agencies to help vulnerable older individuals with problems requiring legal assistance.

Federal funding for projects in this priority area are limited to $200,000 for a maximum duration of 17 months.

2.1.D: Aging Health Promotion—Mental Health

Since 1984, the Administration on Aging has been working with the U. S. Public Health Service on a joint national initiative to develop and expand health promotion programs for older persons. Launched under an interagency agreement, a key objective of this initiative is to encourage collaboration among State and local health departments, State and Area Agencies on Aging, and voluntary organizations in the development of health promotion programs for older persons.

Thus far, the initiative has addressed the areas of nutrition, physical fitness, drug management, injury prevention and smoking cessation. Future efforts will focus on mental health, dental health, prevention of pedestrian and motor vehicle accidents and injuries, immunization, and prevention of fire and smoke-related accidents. This priority area and the two that follow solicit project applications relative to the first three of these future topics: mental health, dental health, and pedestrian and motor vehicle safety.

Available evidence indicates that the elderly have the greatest incidence of mental illness of any age group but that they make infrequent use of mental health resources. Estimates of the prevalence of moderate to severe mental illness in the older population range from 13 to 25 percent, compared to 7 percent in the age group 18 to 64 years. Furthermore, it is generally recognized that the incidence of depression, suicide and dementia increase with age.

The purpose of this priority area is to solicit project proposals for pilot *Statewide* or *Indian reservation-wide* public education campaigns aimed at promoting better mental health among the elderly. The campaigns should be designed to help vulnerable older people and their families identify symptoms of depression, stress and other mental health problems and provide information about where to turn for assistance. Applications should address how proposed projects will overcome the resistance of older persons to utilizing mental health services, and should identify the various channels to

be employed in organizing and implementing a statewide or reservation-wide campaign, taking advantage of experience gained in previous health promotion media campaigns.

Except as may be inappropriate for projects or Indian reservations, proposals should demonstrate collaboration with both the State Agency on Aging and the State Mental Health authority in the conduct of the State-wide effort. All applications should clearly define a strategy that will enlist the efforts of other relevant agencies and organizations including State and/or local mental health associations, Area Agencies on Aging and other appropriate public and private entities.

Applicants should work in conjunction with the existing State health promotion coalition established in connection with the AoA/PHS national initiative on health promotion.

Federal funding for projects in this priority area is limited to $150,000 for a maximum duration of 17 months.

2.1.E: Aging Health Promotion—Dental Health

Older adults are at greater risk of oral and dental disease than the younger population. Periodontal as well as other dental and oral diseases and conditions in the elderly contribute to poor nutrition and poor self-image, often resulting in poor overall physical and mental health. Although many dental and oral disorders are both preventable and reversible, seniors often do not seek periodic dental care or practice regular dental hygiene.

In order to address these concerns, AoA solicits proposals from State Agencies on Aging, State professional associations, schools of dentistry, public health and medicine, and other appropriate organizations to conduct training and public education activities aimed at promoting oral health among the elderly. With respect to training activities, consideration will be given to proposals which:

- Promote and encourage the integration of available geriatric dental knowledge into the curriculum of schools of dentistry and dental hygiene;
- Provide geriatric dental continuing education and training on a state- or region-wide basis for dentists and dental health care workers;
- Develop and provide dental awareness material for other health care providers who work with older persons with emphasis on geriatric dental problems.

Organizations wishing information regarding curriculum content already developed for a graduate level certificate program may contact: Joseph Holtzman, Ph.D., Department of Applied Dentistry, School of Dentistry, University of Colorado Health Sciences Center, Campus Box C 284, 4200 East 9th Avenue, Denver, Colorado 80262. Dr. Holtzman is the director of an AoA-Supported project entitled, "Oral Health Gerontology Fellows Program."

In addition to training for dental health professionals, AoA will consider providing support for projects to undertake *Statewide* or Title VI *Indian reservation-wide* dental health promotion campaigns to encourage preventive dental health practices. Except as may be inappropriate for Title VI Indian tribal organizations, these public education efforts must demonstrate collaboration with both the State Agency on Aging and the State Health Agency with responsibility for dental health programs.

All proposals should clearly define a strategy that will bring together other relevant participants including State and/or local Dental Health Associations, Area Agencies on Aging and other public and private organizations as collaborators in the effort. Proposed campaigns should be designed to educate and motivate older people, their families and caregivers to adopt good dental health practices, to identify symptoms and to locate treatment and information resources. Applications should specify how the statewide or reservation-wide campaign will be organized and implemented, taking advantage of experience gained in previous health promotion media campaigns. Applicants should work in conjunction with the existing State health promotion coalition established in connection with the AoA/PHS national initiative on health promotion.

Federal funding for projects in this priority area is limited to $150,000 for a maximum duration of 17 months.

2.1.F: Aging Health Promotion—Pedestrian and Motor Vehicle Safety

Motor vehicle and pedestrian fatalities are the leading cause of accidental death for older persons age 65–84. Within the age group 65–74, deaths from motor vehicles occur among men more than women by a ratio of 2 to 1. Differences in motor vehicle accident rates among older people are related to the frequency which older persons drive, and their interest and physical ability to walk unescorted outside their homes. Although they travel fewer miles and have fewer collisions than younger drivers, older drivers have a higher collision rate per miles driven. Likewise, although older persons are more cautious than other age groups, they are at greater risk both as drivers and pedestrians due to aging-related changes in their physical and mental reactions in driving and walking environments.

A number of actions can be taken to reduce the incidence of motor vehicle and pedestrian accidents among persons over age 65. Most are similar to actions that would reduce accidents among all age groups: prevention; detection and correction of physical impairments; law enforcement; public education and counseling; improvements in highway and pedestrian walkway engineering; and installation of auxiliary aides and safety devices in vehicles. However, to be effective, approaches along these lines may need to be tailored specifically to the needs of the elderly.

Several noteworthy efforts have already been undertaken. The U.S. Department of Transportation and the American Association for Retired Persons (AARP) have jointly sponsored a driver safety program entitled "Safe Rides for Long Lives," which is directed at encouraging older persons to use seat belts. AARP has also sponsored a driver education/re-education program called "55 Alive," which has resulted in adoption of legislation in 18 States lowering insurance rates for older persons completing this or other certified driver re-education courses. In addition, AARP is currently developing a number of other pedestrian safety educational materials.

In order to increase attention to the issues of driver and pedestrian safety for older persons, AoA solicits proposals for the conduct of *Statewide* public education and awareness programs. Projects should be designed to inform older drivers and the general public about the implications of driving that are associated with advancing age, physical limitations, medications and alcohol, loss of sensory acuity, and reduced reaction times. Projects may also aim to re-educate older drivers and assist them to compensate for loss of perceptual acuity, as well as to cope with hazards which derive from highway engineering or poorly marked roads. Applicants proposing projects covering urban areas are encouraged to consider pedestrian education programs to assist older persons to walk defensively and better anticipate the perils they may encounter due to slower gait or other physical limitations.

Applicants in this priority area are expected to involve the appropriate State and Area Agency on Aging, State and local Motor Vehicle Departments, and national or State organizations concerned with traffic safety in the design and conduct of their proposed

projects. Where feasible, linkages with high school driving and pedestrain safety programs should be explored. In addition, projects are expected to make maximum use of existing materials and programs, including those resources and programs developed by AARP.

Federal funding for projects in this priority area is limited to $150,000 for a maximum duration of 17 months.

2.1.G: Transition of Head Start Students to Public Schools

Previous studies under the Head Start developmental continuity initiative have found that making the transition from a preschool program to a public school program is frequently a period of high stress for both children and parents, due to the larger class size and different roles and approaches of the two kinds of programs. Insufficient attention has been paid to noting the similarities and differences of the two systems and to assisting parents to serve as links, giving continuity to the child during this critical time. Pilot efforts to facilitate transition of children with handicaps has shown that attention needs to be paid to assisting staff in planning ahead for transition and in understanding each other's system, including the differences in staffing patterns and emphasis on child development and academic work.

Demonstrations of locally-designed ways to reduce the stress of transition for children and new parents are needed. Applications should address innovative strategies for assisting parents in transition of Head Start children, including those with handicaps or at risk of abuse or neglect.

Proposals should address the development and demonstration of effective support to parents in the following areas:

- Involving parents actively in planning, carrying out and assessing the transition activities.
- Increasing parental contact between the two systems, including the year before the children make the transition.
- Improving parent information-sharing procedures and increasing parent input in describing the children's interests, motivations and learning styles, along with any special problems or needs.
- Reviewing record-keeping procedures to see if common record items or processes could be designed to facilitate transition. Developing better understanding of the expectations of the public school for children emerging from Head Start (survival skills), particularly for children with special needs.
- Developing support systems within the public school system that involve linkages with other parents.
- Developing ways to implement effective transition assistance activities in public schools and Head Start programs.

Special attention should be paid to developing information on costs involved and amount of volunteer time and in-kind contributions which are needed to operate the project, developing an assessment of the satisfaction with the activities by Head Start and public school staffs and parents and development of a final report which would contain narrative descriptions of strategies tried, both successful and unsuccessful, and cost and satisfaction information, at a minimum.

Under this priority area, eligible applicants include local Head Start programs, or public schools or PTAs in the same geographic area as a participating Head Start program. HDS welcomes applications from Head Start grantees and/or public school systems which reflect a close, collaborative and joint planning approach to increased new parent involvement in the transition process.

HDS anticipates funding 24-month projects having a Federal share not to exceed $12,000 per project per year.

Topic 2: Community Self-Sufficiency

2.2.A: Development of Models Applying the Enterprise Zone Concept to American Indian Reservations

The concept of enterprise zones as a means of attracting business and capital to Indian reservations is getting increased attention. American Indian Tribes have many of the attributes conducive to enterprise zone application, such as tax immunities, jurisdictional prerogatives, and natural and human resources. A bill pending in Congress, entitled the Indian Economic Development Act of 1985 (H.R. 3597) would, if enacted, significantly advance the concept of enterprise zones on Indian Reservations. Title I of the Bill gives the Secretary of the Interior the authority to designate Indian enterprise zones. The areas designated must be selected from nominations made by Tribal governments.

The purpose of an enterprise zone is to attract business and investment capital through packaging and marketing of local resources, attributes and locations. Concerted Tribal efforts will be necessary to enhance the natural advantages of Tribal operations and at the same time reduce the barriers that discourage businesses from beginning or expanding. According to a comprehensive study on enterprise zones completed in 1981, titled "The applicability of Enterprise Zones to American Indian Reservations," certain principal factors are important to industry in determining where to locate. These factors, identified below, should be addressed in the application:

1. Basic economic factors (location, labor availability and skills, land, resource availability, market demand and availability of private capital);
2. Civil order (personal safety, property security, enforcement of contracts and political stability);
3. Taxes and regulations (Federal, State, Tribal and local);
4. Infrastructure/service delivery (transportation access, utilities, site preparation, fire protection, schools and street maintenance); and,
5. Assistance programs (job training, management assistance services, and grants and low-interest loans);

Copies of the above-referenced study may be obtained by writing to the Administration for Native Americans, 330 Independence Avenue, SW., Room 5300, North Building, Washington, DC 20201 Attention: Anita Wright.

Eligibility is restricted to Federally-recognized Indian tribes. Applications should address the planning and setting up of the enterprise zone structure and the implementation of a zone. It is expected that applications addressing both the planning phase and implementation/marketing phase will require two years. Federal funding for projects in this priority area is limited to $250,000 for a maximum duration of 2 years.

Topic 3: Intergenerational Projects

2.3.A: Intergenerational Projects

The widespread establishment of intergenerational programs is one way in which social institutions can help meet the needs of our growing older population. It is also a way in which our Nation's younger members can benefit from the skills and experiences of the generations that have preceded them.

The purpose of this priority area is to encourage public and private non-profit organizations to plan and carry out creative intergenerational programs designed to meet identified community needs. A number of types of intergenerational programs, involving reciprocal benefits for both young and old, would be entertained, including:

1. Educational projects involving the use of older persons in helping youngsters in foster care or runaway youth shelters master basic educational skills. Such projects could have older persons volunteering through child welfare or runaway youth agencies to assist youth with tutoring, counseling and role-modeling. This focus should result in the mastery of specific skills as

well as improved self esteem for youngsters who may have had little positive contact with older persons.

2. Projects in which older people help teach parenting skills to adolescents.

3. Community service projects involving volunteer youth in assisting the homebound elderly or other older persons needing help with home maintenance chores, shopping, transportation, recreational activities, etc. Such projects would assist frail older people in activities of daily living.

All proposals must demonstrate how both young and old benefit from participation in the proposed activities. Projects must describe the specific activities that will be undertaken, including the roles and responsibilities of all participating agencies and organizations. Applicants should propose significant collaboration between child and youth serving organizations, such as runaway shelters and child welfare agencies, and organizations in the field of aging, especially State and Area Agencies on Aging. Applications should describe how the proposed project will have a continuing significant impact on the problems being addressed. Where the project warrants, funding will be jointly provided by the Administration on Aging (AoA) and the Administration for Children, Youth and Families (ACYF). Applications should list all organizations that will collaborate on the project and describe the nature and extent of that collaboration. Written assurances should be included with the application if available.

Potential applicants wishing information about worthwhile and successful intergenerational programs in operation across the country may wish to obtain a copy of a publication titled *A Guide to Intergenerational Programs.* Developed with grant support from the Administration on Aging, the *Guide* is a compilation of information on the content, impact and characteristics of model intergenerational programs. A number of these programs were developed with support from both AoA and ACYF. The *Guide* also provides information on a variety of resources that may be utilized in planning, designing and implementing such programs. Copies of the *Guide* may be available at the State Agency on Aging. Copies can also be obtained by writing to:

National Association of State Units on Aging, 600 Maryland Avenue, SW.—West Wing, #208, Washington, DC 20024—(Price: $15.00)

Federal funding for projects in this area is limited to $50,000 for a maximum duration of 17 months.

Topic 4: Challenge Grants to Community Foundations

Introduction

The purpose of challenge grants to community foundations is to stimulate the development of endowed restricted funds within community foundations for the support of small and medium sized human service organizations in their communities.

It is expected that the efforts will enhance the service capability and financial stability of small and medium sized human service organizations by increasing their support from the private sector and establish liaison among community foundations, public State and local agencies and the private sector.

Grants to community foundations are made for up to three years with submission of a yearly application and are subject to availability of funds. The community foundations must be able to establish an endowed fund of two dollars in new non-Federal funds for each Federal dollar, each year. The non-Federal funds must be assigned to an endowed restricted fund, the future income of which must be used to support small and medium sized human service organizations with emphasis on increased human service to youth at risk, such as runaways, homeless youth, older adolescents in foster care and unemployed low-income youth.

Eligibility

Applicants must:

(1) Meet legal requirements, donations to the organization must be allowable as a charitable contribution under section 170(c) of the Internal Revenue Code of 1954, as amended;

(2) Be a community foundation with public charity status;

(3) Have an endowment or be actively working towards building one; and

(4) Have a giving program which addresses a broad range of community needs.

Subgrants and Selection Criteria for Subgrantee

Community foundations shall propose selection criteria for subgrantees in the applications and upon approval from HDS, select subgrantees who will provide the services.

Grant Amounts

Federal funding for challenge grants to community foundations may range from $35,000 to $100,000 per year for three years and will contain a requirement for submission of annual applications for approval by HDS. Subgrants may range from $6,000 to $35,000 per year for three years with submission and approval of applications annually.

Non-Federal Funds

For every Federal dollar provided each year of the grant, the community foundation must provide two dollars in cash, cash equities, bonds or commercial papers (representing new private funds). Other similar instruments must be approved by HDS.

During the first three years, community foundations will use the Federal funds to award grants to subgrantees. The non-Federal funds must be deposited in a restricted fund (for small and medium sized local human service organizations). At the end of the third year the community foundation shall begin to use the income from the fund to fund subgrantees. The grants would continue to focus on the needs of the youth target population, but could use different project designs after the three-year period.

Review Criteria

Applications will be reviewed based on the following criteria:

(1) Demonstrated ability to provide the non-Federal funds and increase its earnings beyond the grant period (25 points);

(2) Demonstrated ability to understand complex human problems and the services to deal with the problems (25 points);

(3) Ability to coordinate with State and local public and private human service organizations (25 points); and

(4) Creativity in designing service programs for youth at risk (25 points).

2.4.A: Job Clubs for Teenagers

It has been well documented that disadvantaged teenagers often do not know how to look for a job, or how to conduct themselves in interviews or in on-the-job settings after receiving employment. Obtaining and retaining jobs have many positive influences on teenagers. Work produces income, develops self-confidence and discipline, provides valuable experience and provides direction to teenage development. Conversely, lack of work experience, world of work preparation and basic skills development makes it difficult for at-risk youth to move toward independence and self-sufficiency.

One of the problems in assisting teenagers has been the gap between community-based youth service providers and private sector-oriented skills training programs.

Job clubs take a variety of forms, many of which could be suitable for replication. At a minimum, job clubs bring youth together to learn about filling in forms, how to dress for and behave at interviews and how to do role playing. More elaborate forms of job clubs may include a bank of telephones where youth systematically call employers, seeking to promote themselves if an opportunity exists or could be created.

Available literature offers many other useful ideas, and two examples recently funded by HDS may be helpful as references:

Jobs for the Future (JFF) Project, Bank Street College of Education, 610 West 112th Street, New York, New York 10025

Jobs Independence for Youth (JIFFY) Project, New York State Department of Social Services, Bureau of Program Development, 40 North Pearl Street, Albany, New York 12243

HDS is soliciting proposals from community foundations which will establish a job club(s) through subgrants to local public or private community organizations. Job clubs for disadvantaged youth, using volunteers and involving the private sector, should establish comprehensive employment programs which include critical elements such as: Orientation to the world of work, recruitment, intake, provision of information on employer needs, eligibility for public sector jobs, how employers make selections, skills training, academic remediation, support services and job placement.

Periodic meetings with teenagers to discuss their experiences, issues and problems should also be considered. Private sector involvement in the design and volunteer aspects of the program is recommended.

HDS anticipates Federal funding levels of approximately $65,000 per year per project.

2.4.B: Mainstreaming Troubled Youth

This priority area addresses the idea of brokering new pathways for low-income youth in the social-human services system to enter or reenter the mainstream life of their community.

According to a report by the Advisory Commisssion of the Education Commission of the States, as many as 10 to 15 per cent (2.4 million) of our youth are disconnected from work, school, family and other societal anchors. As of 1983 there were 269,191 children and youth in foster care in the United States. Thirty-nine per cent of these were between the ages of 13–20 and 25 per cent were between the ages of 6–12. Only approximations have been made of the numbers of homeless youth, who are defined as "persons under 18 years of age and in need of services and without a place of shelter where he or she receives supervision and care." Of the number of youth seen in the runaway shelters, the Department estimates that approximately 35.5 percent are homeless.

Generically, HDS programs offer shelter care; intervention; protection and rehabilitation. There is, however, another dimension to be addressed, that of additional motivation, socialization and support at the point where social service programs leave off and self-sufficiency begins.

Traditional organizations in the community (Girl Scouts, Police Boys and Girls Clubs, fraternities, sororities, etc.), that do not usually deal with these subpopulations have much to offer in this area. Their programs already include constructive use of leisure time, reinforcement of positive decision-making, strengthening self-esteem and self-awareness, adult role models, peer support, skills building, community service etc. The target populations of this priority area are the hidden clientele of numbers of such organizations who presently perceive working with troubled youth as "risk venture programming."

Some successful models have emerged which address this idea. What appears to be a key factor is the involvement of a local advocate group as a broker who will work with one or more local organizations to develop programs, provide training, and assist these organization to focus on this population and begin to work with social service agencies. Some examples of such efforts include the following:

• A Girl's Emancipation Program of a YWCA, a residential, transitional project, assists adolescent girls to successfully establish independent life syles in the community. The program offers intensive, short term services to these girls for whom emancipation is an appropriate goal but who are unable to successfully move into independent living due to significant emotional and social concerns, as well as insufficient family and community support.

Services are provided on both a residential and out-client basis for approximately 90 days, and on an "as needed" basis for an additional 90 days after emancipation.

• A program based on the Camp Fire, Inc. Reflections Project assists young adolescent girls ages 13–16, who are primarily, but not exclusively, status offenders. The program helps these girls develop a positive self-image; provides an opportunity to discover personal talents and abilities; helps develop the skills necessary for independent decision-making; and to discover positive uses for leisure time.

To date, these successes have occurred: detentions at school have decreased, grades are beginning to improve; solving differences with words (rather than fists) is becoming more commonplace. These girls are not only learning how to have the system work for them, but also they are experiencing positive interaction with caring adults.

Runaway and homeless youth shelters and coordinated networks not only provide short term shelter care and counseling for troubled youth they also spend a major portion of their time and resources brokering the youth and their families into the appropriate service system for addressing their longer term needs. In this capacity and in their education/prevention efforts, shelters have become strong youth advocates in their communities. This priority area would like to involve community foundations and build on the advocacy role and talents of shelters to develop the concept described above.

Community foundations are invited to submit proposals in which appropriate organizations, e.g., runaway and homeless youth shelters, will be selected as brokers that provide technical assistance to one or more local organizations to develop appropriate programs to aid in the mainstreaming of youth in foster care and recently emancipated youth, and homeless youth in independent living programs.

The proposals should include: collaboration with local youth serving organizations such as Boy Scouts, Girl Scouts, Camp Fire, Big Brothers/Sisters, etc.; an outline of the program to be developed; and some indication of interest by the local social services agency involved. Applications should describe how the proposed project will have a continuing significant impact on the problems being addressed.

Projects will be three years in duration. The broker subcontracted for by the foundation should be prepared to work with at least one new traditional organization each year.

HDS anticipates funding 36 month projects having a total Federal share not to exceed $50,000 per project, per year.

Section 3: Dissemination and Utilization

3.1.A: Expand or Improve Social Service Delivery to Native American Communities by Packaging and Disseminating Successful Approaches and/or Implementing Models in Other Native American Communities

Successful approaches to programs relating to the development of social structures within Native American communities need to be disseminated so that other communities may benefit from these models in forming programs aimed at strengthening their own social development. Too often, Native American communities devote too much attention to reporting the success of economic development projects to the detriment of the development of social projects.

The philosophy of the Administration for Native Americans in the formulation and implementation of the Social and Economic Development (SEDS) program strategies is based on the principle that social and economic development are interrelated areas. Therefore, underreporting of successful social programs tends to impede the balanced delivery of programs which would result in an efficient and effectively-planned development of Native American communities. Synthesizing, packaging and disseminating or replicating successful approaches and outcomes for social projects is of critical importance.

Toward this end, the Administration for Native Americans is interested in entertaining proposals which incorporate successful approaches to social services and disseminate the outcomes of such projects. Applicants should demonstrate a strong marketing capacity in their proposal. In addition, they should identify those successful projects which they propose to market through this award. Other desirable significant factors include:

- The degree to which the project utilizes linkages with existing public and private social service providers.
- The degree to which the project increases Native American self-determination in the delivery of social services by promoting local control over planning, implementation, and administration.
- The degree to which the project supplements the absence of family support networks, especially for the institutionally vulnerable and/or otherwise at-risk or needy populations.
- The degree to which the project promotes self-reliance of individuals and families by providing needed services using culturally appropriate methods, and decreases dependency on local, State and Federal welfare programs.

Federal funding for this priority area will be limited to $150,000 for a maximum duration of 17 months. Eligibility is restricted to Tribal governments and Native American organizations. However, they are strongly encouraged to enter into partnerships with other public or private sector entities in these applications.

3.1.B: Development of New or Replication of Successful Placement Efforts in Special Needs Adoption

For the past nine years there has been extensive work in the field of adoption of special needs children. Model programs on recruitment, placement, post placement and post adoption services have been developed, demonstrated and disseminated; a curriculum has been developed, and widely distributed and States have received grants to improve and enhance their special needs adoption programs.

We are seeking to replicate effective programs for the adoption of children with special needs such as Wednesday's Child, One Church-One Child, and Friends of Black Children. Other successful efforts have included the use of videotapes to feature waiting children and partnerships between adoption agencies and the corporate sector.

In addition, HDS will consider demonstrations of innovative practices which may have the potential of replication. These efforts should be directed to overcoming barriers to the successful adoption of children with special needs. Such projects may address staff training, child-parent preparation, public awareness, or any aspect of special needs adoption in which successful practices have or need to be further developed.

HDS anticipates funding 17 month projects having a Federal share not to exceed $100,000 per project. Private, non-profit, voluntary agencies and public agencies are eligible to apply. Grants from public and private agencies will be considered separately and awards will be made to both types of agencies.

3.1.C: Temporary Child Care for Handicapped Children and Children in Need of Protection

Currently-accepted policy goals of strengthening family life and enhancing parental capacity to care for children require new forms of assistance and support for parents who are overstressed and temporarily incapacitated in providing appropriate care. Under this priority area, HDS in interested in two different types of support for such parents: respite care and crisis nurseries.

- Many families provide care for severely handicapped children, those with chronic or terminal illness and those with severe emotional and behavioral problems. In some instances, these parents are adoptive or foster parents.

Respite care is a promising approach to providing short-term relief to persons primarily responsible for the daily care of children who have these conditions. Respite care has not been utilized extensively by child welfare agencies despite its high potential for supplementing family care, thereby improving the quality and stability of the child's placement in the community.

Respite care can be used to prevent placement, reduce the incidence of multiple foster home placements and strengthen the long range parenting commitments of foster and adoptive families. A range of models have been used including in-home care, foster home care, residential care designed exclusively as respite care and cooperative parenting.

HDS is interested in replicable demonstration projects that apply known concepts and practices concerning the use of respite care and which assist biological, foster and adoptive families. Projects are required to develop handbooks or other resources which can be disseminated.

- Many young parents and single mothers find themselves temporarily overwhelmed in providing adequate care to infants and young children. Stresses due to low income, social isolation, and lack of family or neighborhood support networks are commonly reported by parents who have been investigated for abuse or neglect of their young children.

Crisis Nurseries have long been recognized as an important resource for parents under stress, in providing a respite to meet a current crisis, as a point for positive contact and involvement with isolated parents, and as a critical community service to prevent child abuse and neglect.

HDS is interested in proposals to establish crisis nurseries. Programs should specify links to child protection and to other programs in the community which constitute the child abuse prevention system, and should describe plans for community education to encourage appropriate use of the crisis facility, links to parent education, and referral for other needed services.

Projects should develop handbooks or other resources which can be disseminated.

Applicants should list organizations that will work on the project along with a brief description of their contribution. Written assurances should be included with the application if available. HDS anticipates funding 17 month projects in the area of respite care having a Federal share not to exceed $60,000 per project. We also anticipate funding 17 month projects in the area of crisis nurseries

having a Federal share not to exceed $100,000 per project.

3.1.D: Assessment of Local Agency Adoption Efficiency

States and local communities have taken the initiative to improve the performance of public adoption agencies. This is a consequence of their increased efforts to find permanent adoptive homes for children with special needs—school age, handicapped, minority and sibling groups. California and other States have developed quantitative and descriptive methods to assess local public agency adoption performance. These techniques annually inform State policy and administrative decisions affecting the allocation of staff, resources, and technical assistance to advance and improve adoption services. The development, improvement and implementation of assessment techniques that improve local agency adoption services are the foci of this priority area.

• *Development and Implementation of Feasible Assessment Models.*

California has legislation that mandates the establishment of annual goals and recommendations regarding the improvement of the performance of public adoption agencies. The "Public Agency Efficiency Report" is an intensive comparative analysis of the adoption efficiency among the counties based on quantitative measures and field visits. Three measures are used, the number of adoption placements less the number of adoption disruptions divided by the full time equivalent (FTE) adoption workers and supervisors. There are two other measures which are closely related.

Based on the ranking of all the counties, the lower half of the counties that are less efficient are field visited for intensive descriptive assessment of adoption process and contextual factors. The quantitative and descriptive information is used to establish efficiency goals for the next year.

HDS will consider projects that essentially implement the adoption efficiency system used in California. The system may be modified to meet the individual State needs.

HDS anticipates funding 24 month projects at a value not to exceed $50,000 to $100,000 per project, per year.

Applications are restricted to States with 500 or more children in need of adoptive homes.

Information concerning California's "Public Agency Adoption Efficiency Report" is available at cost from National Resource Center for Special Needs Adoption, P.O. Box 337, Chelsea, Michigan 48118, telephone (313) 475–8693, Contact: Nancy Burkhalter.

• *Developing and Implementing Alternative Measures of Adoption Efficiency.*

Applications should describe the development of alternative quantitative measures to assess local public agency adoption efficiency or effectiveness. The measures should be valid, reliable and feasible to implement and inform the State and local policy and administrative decision process. The measures may be supplemented with qualitative approaches to identify adoption system weaknesses which impair the State's goal to place special needs children in adoptive homes. These approaches may take into consideration work measurement, or other analytical techniques.

HDS anticipates funding 24 month projects having a Federal share not to exceed $50,000 to $100,000 per project, per year.

Applications are restricted to State agencies.

Section 4: Research and Evaluation

4.1.A: Development of Measures for Assessing the Performance of State Agencies on Aging

This priority area calls for the development and field testing of an instrument that can be used by State Agencies on Aging to evaluate how well they are carrying out their major responsibilities. What is envisioned is a protocol that can be self administered and that compels critical analysis of the strengths and weaknesses of State Agencies on Aging in the performance of their most important functions. The instrument might take any one of several forms (or be a mix of approaches)—a series of open-ended probes, checklists, statistical measures of performance, etc. The final instrument should be applicable to all State Agencies on Aging and should be sufficiently easy to use so as not to discourage voluntary application on the part of State Agencies interested in formal self-evaluation.

Applications should discuss the conceptual framework within which instrument development will be undertaken; the process by which the instrument will be developed—including how content areas and specific items will be identified and defined; the use of advisory panels; and the field-testing plan that will be employed.

It is anticipated that a major challenge in executing this type of effort will be the achievement of a workable consensus regarding the concrete specification of functions for which State Agencies on Aging should hold themselves accountable, and the development of yardsticks that can provide reasonable measures of success. Applications should discuss how these issues will be approached.

Federal funding for applications in this priority area is limited to $200,000 for a maximum period of 17 months. For-profit organizations are eligible to apply. Non-Federal funds must comprise at least 5 percent of the total cost of project under this priority area.

4.1.B: Assessment of the Relationship between Social Services for the Elderly Provided through Title III of the Older American Act and the Social Services Block Grant Program

Two major Federal programs currently provide funds for the provision of social services to the elderly: Title III of the Older Americans Act (OAA) and the Social Services Block Grant Program (SSBG). Under both authorities States and localities have broad discretion with respect to how the programs are organized and administered, how and by whom services are delivered, what services are provided, and who is actually served.

Research proposals are solicited which identify the principal effects, primarily at the local level, of having two separate Federal funding streams and of having, in many cases, two separate systems for the delivery of services to the elderly. The central issue to be addressed by studies in this priority area is: "What are the consequences of having two Federal social service programs providing service to the elderly?"

In exploring this issue, information and analyses should be generated on the following kinds of questions:

• Who is served? Is there a difference between the elderly clients served by the two programs?

• What services are being provided? Are the services made available to the elderly under the two programs the same or are they different?

• Do the two programs utilize the same service providers?

• Do the costs for the same services differ under the two programs? What accounts for the variation?

• What is the nature and extent of coordination between the two programs at the local level? Do the programs operate in light of one another or are they viewed as essentially separate? Is there joint planning, policy development and implementation?

• What innovative/effective management models have been developed to coordinate the two programs insofar as services to the elderly are concerned?

It is anticipated that findings from the proposed study will encourage State and local officials to review programmatic and management policies governing the manner in which the two programs are operated within their jurisdictions. If sufficiently compelling, the findings could precipitate improvements in targeting, cost control, and coordination at State and local levels where key management decisions are made. Reports resulting from the proposed study should be written in a manner that will be useful to policy-making officials at these levels.

Proposals in this priority area must clearly outline the issues to be addressed and the research design to be employed.

Federal funding for projects in this area is limited to $200,000 for a maximum of 17 months. For-profit organizations are eligible to apply. Non-Federal funds must comprise at least 5 percent of the total cost of projects under this priority area.

4.1.C: Risk Assessment Systems Utilized by Child Protective Services in the Decision-Making Process

Cases of child abuse and neglect reported to child protective services agencies vary in their urgency for immediate investigation and in the complexity of the decisions needed to protect the child while respecting the rights of parents and minimizing any unwarranted intervention into family life. Difficult decisions which convey risks for the child, the family and the agency must be made. They include: the speed with which an investigation should be undertaken, the involvement of other professionals or community agencies, the extensiveness of data to be gathered in the investigation, the provision of emergency protective services for the child (in or outside the home), the removal of the child or the perpatrator when it is essential to separate the two, the need to initiate juvenile or criminal court proceedings, and when to return the child to the home.

Agencies have begun to identify risk factors and to implement systems to assess risks for the child, for the family, and for the agency in arriving at decisions in the handling of a case.

Research is needed to examine current risk assessment systems more closely to identify the criteria used at various stages in the decision making process. Examination is also needed of methods used to establish acceptable levels of risk, as well as how information is feeded back into the system to improve services and reduce risks for children, families and the agency.

HDS is interested in considering proposals which address the foregoing issues and which measure the effectiveness of current practices in risk assessment, and which identify best practices. Appropriate agency collaboration is recommended, and written assurances should be included with the application where available. Proposals should also show the ability to gain access to necessary information.

Proposals for up to 24 months in duration with Federal funding not to exceed $200,000 will be considered.

Non-Federal funds must comprise at least 5 percent of the total cost of project under this priority area.

4.1.D: Abused and Neglected Children Involved in Court Actions

According to the American Human Association (AHA), the number of child abuse and neglect cases referred for court action has increased substantially since 1980. Cases referred to the court include some of the most serious forms of child abuse and neglect, and many are especially challenging for child protective service workers, law enforcement officers, prosecutors, and court personnel. Child protection, removal of the perpetrator or the child from the home, prosecution of the perpetrator, and child custody are among the issues requiring court action. In some instances, more than one court may be involved in different aspects of the case. The extent of coordination among the courts, child protective service agencies, and other entities in the community varies in jurisdictions across the country.

Little is known about (1) the experiences of abused or neglected children and their families in court cases, or (2) the effectiveness of the court's involvement in resolving the multiple issues facing the child victim or the family. For example, where the primary concern of the court may be the prosecution of the perpetrator, the consequences for the child victim and the family may not be clearly understood.

Research is needed on the impact of court involvement on abused or neglected children and their families, including comparisons of similar cases in which: prosecution is or is not pursued in a criminal court; cases are heard in juvenile or family courts; mediation is used as an ancillary service of the court or outside the court; cases involve the prosecutor but not the court; or there is no involvement of the court or its related entities.

Issues of concern include: the type of abuse or neglect, age and sex of the child, relationship of the perpetrator and the child, the nature of the court's involvement, how the court becomes involved, the extent to which the court depends on and interacts with the child protective service agency and other community agencies in considering cases, the various stages in the process and associated time lines experienced under varying conditions, services provided for the child or family while the case is in process, case disposition and follow-up services.

Applications should list all the organizations that will work on the project, along with a description of the nature and extent of their collaboration. Written assurances should be included with the application if available. Applications should show that applications will be able to gain access to necessary information.

HDS anticipates funding projects of up to 24 months in duration having a Federal share ranging from $75,000 to $125,000 depending on the proposed work.

Non-Federal funds must comprise at least 5 percent of the total cost of projects under this priority area.

4.1.E: Methods Used in Interviewing Child Victims

Anatomically correct dolls have increasingly come into use in interviewing children to elicit information about what actually happened when child sexual abuse is suspected and the child is asked to relate the events which occurred.

The use of dolls has proliferated absent systematic evaluation of the validity of the information obtained, the role of the interviewer, the suggestive aspects of the dolls or comments made by the interviewer, changes if any over time and different intervies, differences in information obtained in investigative vs. therapeutic environments. Although the National Center on Child Abuse and Neglect recently funded one study on the interaction of abused and non-abused children with anatomically correct dolls, additional investigations are needed to establish more empirically-based means for this and other techniques used in interviewing child victims.

Studies are needed to examine a range of child and interviewer variables to determine differential child responses, how different interviewing techniques affect the ability to elicit information for children of different ages, stages in development, cultural and ethnic backgrounds, and children who have suffered different types of abuse. Attention also needs to be given to the interpretation of data obtained

from children under varying circumstances.

Applicants should demonstrate knowledge of the literature in child psychology, child psychiatry, early childhood development, protective services procedures and posess the appropriate background and experience in research methodology.

HDS anticipates funding projects for up to 24 months in duration with Federal funding not to exceed $125,000 per year.

Non-Federal funds must comprise at least 5, percent of the total cost of projects under this priority area.

4.1.F: Removal of the Perpetrator versus Removal of the Victim from the Home: Effects on the Victim and the Family

Traditionally, efforts to protect children which could not be managed within the home have resulted in out-of-home placement for children. Little attention was given to the emotional or psychological effects on the child being removed from the home, or the further victimization of the child victim. More recently, concerns have been expressed that removal of the child from the home may suggest that the child doesn't fit or belong in the home, and feelings of guilt and responsibility for the events which the child may be experiencing may be intensified.

When the protection of the child requires separation of the child victim and the perpetrator, in some jurisdictions child protective service workers and judges have begun to seek voluntary and sometimes involuntary removal of the perpetrator from the home rather than the child. The results have been mixed, working well in some situations and poorly in others. When the perpetrator is highly motivated to receive treatment and leaves the home voluntarily, there may be a better likelihood for a positive result.

When the perpetrator leaves the home, the remaining members of the household may resent and blame the child victim. When the perpetrator is ordered out of the home and is unwilling to remain out of the home, enforcement of the order is difficult particularly if the remaining household members are sympathetic to the return of the perpetrator.

Studies are needed to determine the impact of removing the child vs. the perpetrator from the home, and to determine the circumstances under which one or the other would be more effective in protecting the child and rehabilitating the family. Criteria for removal of the child or the perpetrator need to be established with attention to the status of the child and the perpetrator in the family constellation and their various relationships. Differences that need to be examined include: the nature of the maltreatment experienced by the child; child status such as only child, one of several children, step-child, foster child, adopted child, biological child; the relationship of the perpetrator to the child, e.g. mother, father, step-father, mother's paramour, etc.; and, the relationships among siblings and other household members. The management and supportive services needed by the child and the family to help achieve a positive result also need to be identified.

While the most pressing need for this research is in the management and treatment of child sexual abuse, attention also needs to be given to other areas of abuse and neglect. Studies proposed need not address all areas of maltreatment but should be clear on what will be studied. Clear access to sufficient numbers of cases for study should be demonstrated in the application.

HDS will consider studies in the area for up to 36 months having a Federal share ranging between $75,000 and $125,000 per project per year.

Non-Federal funds must comprise at least 5 percent of the total cost of projects under this priority area.

4.1.G: The Relationship of Child Maltreatment to Childrens' Social and Emotional Development and School Performance

There is clear evidence that child maltreatment affects the growth and development of children in diverse ways. A recent analysis of the National Study of Social Services to Children and Their Families (1977) data indicate that while 84 percent of elementary school age children nationally are in their modal grades or higher, only 64 percent of children receiving home-based services for neglect are at grade or higher; and, for children between the ages of 14 and 17, 76 percent nationally are at modal or higher grades relative to only 48 percent of those under the care of social service agencies for child neglect.

HDS is interested in examining the impact of neglect and abuse on children's school performance and their social and emotional development. Research is needed to answer the question of the extent to which child maltreatment inhibits the child's development and performance in school, and to identify the extent to which remedial programs to serve these children may be needed. A secondary concern is to determine the extent to which poor school performance may be used as an indicator of potential child maltreatment.

HDS will consider proposals to address the relationship of child maltreatment, including lack of supervision, and other family factors which inhibit the child's social and emotional developmental progress and performance in school. The nature and extent of remedial programs and services that are available for the children should be addressed, as well as the extent to which local child protective service agencies, school social workers, and other school personnel interact on behalf of the child should also be examined. Proposals to study the extent to which poor school performance may be used as an indicator of potential child maltreatment may be submitted as a separate study.

Applications should list all organizations that will collaborate on the project, along with a description of their contribution. Written assurances should be included with the application if available, especially from appropriate school officials. Applications should also show that applicants will have the ability to gain access to necessary information.

HDS will fund studies ranging in duration from 17 to 24 months with Federal funds of up to $150,000 per year depending on the questions to be answered, the intensity of the effort proposed, and the generalizability of the results which may be anticipated.

Non-Federal funds must comprise at least 5 percent of the total cost of projects under this priority area.

4.1.H: Assessing the Impact of Child Abuse and Neglect on Victims

Literature indicates that child abuse and neglect have long-term impacts on the victims which may not be evident for years after the incident and subsequent intervention.

Research is needed to study the residual effects of various types of child maltreatment, the nature of the impact, and its manifestations at critical developmental periods throughout the child's maturation and adulthood. This should include aggregate information about childrens' developmental status, age, geographic location, sex and cultural and ethnic background of the child (so long as the confidentiality of information about individuals is protected), as well as the family context at the time of the incident and subsequent treatment services provided.

At the present time, HDS has underway four studies which were funded in Fiscal Year 1985 to assess the impact of child sexual abuse on victims. Therefore, such studies on child sexual abuse are not planned for solicitation for Fiscal Year 1987.

Research on the impact of physical abuse, neglect (including lack of supervision) and emotional maltreatment on victims is needed. Two studies funded by HDS in Fiscal Year 1984 on lack of supervision can provide background information for research in this area. Two research studies on emotional maltreatment, one pertaining to operational definition and the second to study the effects of emotional maltreatment, are getting underway in Fiscal Year 1986 and they will also be helpful when completed.

Needed are both retrospective and short-term follow-up studies on victims of child abuse and neglect to determine the residual effects after the conclusion of treatment in the areas of physical abuse, neglect, including lack of supervision, and emotional maltreatment.

HDS anticipates funding projects of 17 to 24 month duration having a Federal share not to exceed $150,000 per project, depending on the scope of work.

Non-Federal funds must comprise at least 5 percent of the total cost of projects under this priority area.

4.1.I: Effectiveness of Child Abuse and Neglect Prevention Programs

The disturbing increases in the numbers of children abused or neglected who are coming to public attention, particularly as concerns sexual abuse, have resulted in a diversity of efforts to combat the problem. While it is essential that more effective ways be found to identify, handle and treat cases to remedy the situation for children who have been abused, many believe that solutions must be found in programs to prevent child abuse and neglect. This concern has manifested itself in the establishment of Children's Trust Funds and other funding mechanisms designed specifically to support child abuse and neglect prevention activities, and was recently recognized by the Congress in the enactment of Pub. L. 98-473, legislation to provide Challenge Grants to States to further encourage State child abuse and neglect prevention activities.

Through these combined efforts many programs have emerged in the name of prevention. Some prevention programs have been designed to enable children to protect themselves; some have been designed to educate and prepare young parents for the difficulties of child rearing; some, such as self-help groups, have been directed to parents who have maltreated a child or who feel vulnerable to such behavior; some community-based programs have provided respite care, in-home services, and other assists to families at risk of abusing their children; and some have been designed for community education. Little is known about the effectiveness of these efforts. The rapid emergence and implementation of these programs has not been paralleled with systematic studies of effectiveness.

Research is needed on the effectiveness of the various child abuse and neglect prevention approaches such as those characterized above. Proposals may focus on one or more of the areas mentioned and should attend to both intended and unintended consequences (positive or negative) of various prevention approaches with particular emphasis on how they affect children and families. Applications should list the organizations that will work on the project along with a brief description of their contribution. Written assurances should be included with the application where available. Applications should also show that applicants will have access to necessary data.

HDS anticipates funding projects of 17 to 24 months in duration with Federal funding of up to $150,000 depending on the proposed scope of work.

Non-Federal funds must comprise at least 5 percent of the total cost of projects under this priority area.

Section 5: Education and Training

Topic 1: Education and Training in Aging

5.1.A: Statewide Short-Term Training and Continuing Education for Professionals and Paraprofessionals

AoA solicits applications for the provision of short-term and continuing education and training opportunities for professionals and paraprofessionals, who, in the execution of their duties, serve older persons. These professionals and paraprofessionals include, but are not limited to, nurses, home health and nursing home aides, pharmacists, mental health counselors, hospital discharge planners, homemaker aides, respite care and day care personnel, community health center personnel, nursing home administrators and others.

Eligible applicants include State Agencies on Aging, State professional associations, colleges and universities. Each application should include the following:

(1) A statement clearly specifying the *single* profession or occupation that is being targeted and the number of persons who are expected to be trained. The application should specify how the expected level of participation in the proposed training activities will be achieved.

(2) A plan to conduct *Statewide* continuing education and short-term training for the single targeted profession or occupation targeted. Applications which do not offer training that will impact on a targeted profession or occupation *throughout the State* will not be funded.

(3) In every case, the State Agency on Aging and a State or other appropriate association representing the targeted profession or occupation must be partners in the project. Applications should list all the organizations that will collaborate on the project along with a description of the nature and extent of that collaboration. Written assurances should be included with the application where available.

Applicants may apply for support for a number of different professional or paraprofessional occupations within the State. However, each proposal must target a *single* professional or paraprofessional occupation and show promise of significant impact on that occupation and subsequently on the elderly throughout the State.

(4) The applicant should present a training plan which shows how existing training materials will be used wherever possible. This requirement stems from the fact that the development of a great variety of curriculum materials has already been supported by AoA and other Federal, State and private efforts and not every project need develop new materials.

(5) Applications must describe how project products will be disseminated to other State Agencies on Aging and to the national associations representing members of the targeted profession.

Applications may not propose training for individuals for whom the State Agency on Aging has primary training responsibility as described under section 308(a)(1) of the Older Americans Act, i.e., "short-term training to personnel of public or non-profit private agencies and organizations engaged in the operation of programs authorized by this Act."

Federal funding for projects in this priority area is limited to $150,000 for a maximum duration of 17 months.

5.1.B: Aging Content in Professional Academic Training

The Administration on Aging encourages the inclusion of aging content in programs leading to certification or an academic degree for persons preparing for employment in occupations that significantly impact on the elderly population. Professionals and paraprofessionals who would benefit from specialized gerontological or geriatric content in their career preparation programs include nurses, home health aides, physicians, pharmacists, mental health counselors, nursing home administrators and others.

Applications are requested from institutions of higher education, State Agencies on Aging and State professional associations for the purpose of training persons in a specific professional or paraprofessional occupation. The training should focus on aging concepts and best practices for working with the elderly. Each application should include the following:

(1) A statement clearly specifying the *single* professional or paraprofessional occupation to be targeted.

(2) Evidence that the State Agency on Aging has been significantly involved in and supports the design of the training proposal, if the State Agency is not the applicant.

(3) Evidence that the proposed activity is in response to documented needs for aging content in the profession targeted for training.

Applicants should identify and adapt existing aging education and training curricula to the needs of the program. Information on curricula that have been developed with AOA support is archived in four major clearinghouses. Information may be obtained by calling Project Share (301) 231–9535; the National Technical Information Service (703) 487–4650; the American Association of Retired Persons' "Ageline" (202) 728–4575; and the Government Printing Office Library Programs Service, Micrographics Unit (202) 783–3238.

Applications must include a plan to collect and report information on students participating in the proposed program. The information, to be collected and reported at the beginning and end of the project, must include: (1) Number of students in the program; (2) Aggregate demographic characteristics including such factors as sex, race, age and geographic background of the students (i.e., urban or rural) so long as the confidentiality of individuals is assured; (3) Types of courses and practical experiences; and, (4) Upon each student's graduation, the employment secured.

Federal funding for projects in this priority area is limited to $150,000 for a maximum duration of 17 months.

5.1.C: Minority Training and Development

The Administration on Aging is interested in increasing the number of minorities in management positions in State and Area Agencies on Aging as well as in other organizations impacting the elderly. In order to accomplish this goal, applications are solicited from State and Area Agencies on Aging, Indian tribal organizations funded under Title VI of the Older Americans Act and other appropriate agencies and organizations to participate in a minority internship program. The program is intended to place college graduates, with either significant prior aging program experience or with graduate degrees, as management interns in organizations serving the elderly. Applications should contain information about the host agencies, information on procedures for selecting and recruiting interns, a description of the internship itself, and information about training and supervision associated with the internship.

Finally, applicants should describe fully what steps they plan to take to assure that, when the internship is completed, the intern will assume a management position in an organization serving older persons.

The level of Federal financial participation in projects under this priority area is limited to a maximum of $1,000 per internship per month. Thus, for example, a project proposing an internship program lasting for nine months and involving ten interns may apply for a maximum of $90,000 in Federal funding. Applicants are encouraged to obtain other contributions in support of their internship programs. Any such support will not be subjected to the $1,000 per internship-per-month federal cost constraint.

The per-project level of federal funding in this priority area is limited to $150,000 for a maximum duration of 17 months.

5.1.D: State Agency on Aging Collaboration with Other Agencies

State Agencies on Aging must establish strong linkages with other State agencies which directly affect the lives of the vulnerable elderly. The intent of this priority area is to facilitate the development by State Agencies on Aging of linkages with other key State agencies with which there must be cooperation and collaboration to achieve more comprehensive and coordinated services for vulnerable older persons in the community. Such State agencies may include those providing public health, mental health, housing, transportation and other services.

Applications are solicited from State Agencies on Aging which propose joint training, technical assistance and information transfer efforts with one other State agency and its service delivery network. Applications should:

- Describe joint development by the State Agency on Aging and the other participating State agency;
- Explain why the State Unit on Aging has chosen to collaborate with the other agency, including what is expected to be achieved as a result of the joint effort;
- Describe the existing working relationships between the collaborating agencies;
- Identify the collaborative activities to be undertaken and the plan for implementing them; and
- State the anticipated measurable outcomes.

Applications should list all organizations that will collaborate on the project and describe the nature and extent of that collaboration. Written assurances should be included with the application if available.

Proposed joint training projects should be structured to:

(1) Educate the appropriate non-aging State agency personnel, and the personnel associated with that agency's local service delivery system about:

- Gerontological concepts;
- The States' aging service delivery system;
- The Older Americans Act;
- Service delivery system integration strategies; and
- Other matters related to services for the elderly within the State.

(2) Increase the understanding of State Aging Agency and aging network personnel about the purposes, policies and procedures of programs of the other State agency and its service delivery system.

(3) Have a State-wide impact on the service systems and personnel of both participating agencies and contribute toward the development of improved coordination of service delivery systems affecting the elderly.

Federal funding for projects in this priority area is limited to $200,000 for a maximum duration of 17 months. Eligibility is restricted to State Agencies on Aging and only one application per State may be submitted.

5.1.E: Orientation and Education for Elected Officials

In each community in the Nation, any older person, individually or with the help of family or friends, should be able to find appropriate help to live independently in the community for as long as possible. This can be achieved only through the development of comprehensive and coordinated community-based systems of service that are highly visible and accessible to all older persons and their caregivers.

To be truly responsive, community systems must serve as reliable resources for help in meeting individual needs by making available a full continuum of services to all older persons, with special attention given to the needs of the vulnerable elderly. To be effective,

such systems must be tailored to the requirements and circumstances of individual communities. The resources to support such systems must come, ideally, from a variety of public, private and voluntary organizations, as well as from individuals, and must be utilized in a coordinated manner, reflecting a common understanding of the needs of the elderly in each community.

In most communities, a number of systems already exist which provide a variety of services; in many cases, unfortunately, they operate essentially autonomously and parallel to each other. They usually do not have planned, intermittent points at which they purposefully meet, nor do they share common goals and procedures.

Concerted action must be taken to develop more responsive community systems that are capable of addressing the service and support needs of our frail and impaired elderly and their families. What is needed are broad-based community efforts to effectively link existing service systems and subsystems so that they operate with common goals, have planned points of interaction, and utilize agreed-upon procedures.

Although State and Area Agencies on Aging have the primary leadership responsibility for serving as catalysts or brokers in helping to create responsive community service systems, many other organizations, groups and individuals also have key roles to play. This priority area is focused on one such group: Publicly elected State and local officials. As members of legislative bodies, as executive officials, or as members of quasi-independent regulatory bodies, elected officials are often in positions of unique influence and authority over matters bearing upon the general health and well-being of elderly citizens. However, many of these officials—whether at State, county or city levels—do not have ready access to information about issues related to the elderly within their States and local jurisdictions. Many may be unaware of the service systems which currently exist, of how such systems interact, and of the nature and extent of problems experienced by older persons and their families in securing needed assistance.

The purpose of this priority area is to solicit project proposals from State and Area Agencies on Aging as well as from other qualified organizations for the purpose of orienting and educating elected officials with respect to issues relating to the elderly and about what can be done to build responsive service systems.

Applications in this priority area should:

1. Identify the elected officials who will receive the proposed orientation/education;
2. Specify the content of the proposed orientation/education, including how it will focus on various aspects of community "systems-building" and the need for public, private and voluntary sector collaboration;
3. Identify who will deliver the orientation/education program, over what period of time and at what locations; and
4. Intimately involve the applicable State or Area Agency on Aging in the development and implementation of the orientation program—if the applicant is an organization other than a State or Area Agency on Aging.

Federal funding for projects in this priority area is limited to $200,000 for a maximum duration of 12 months.

Topic 2: Education and Training Related to Services for Children, Youth and Families

5.2.A: Stimulate Community College Involvement in Competency-Based Child Development Associate (CDA) Training for Child Care Givers

The number of infants, toddlers and 4 and 5-year old children in group programs has multiplied dramatically in recent years in public school kindergartens, pre-kindergartens, Head Start programs, day care, and many other privately and publicly-funded settings. Families place great trust in the staff of these programs, and it is the daily performance of the teacher or caregiver that determines the quality of the children's preschool experience. The Child Development Associate (CDA) competency standards and assessment system have been developed to support quality programs for preschool children by providing standards for training, evaluation, and recognition of teachers and caregivers based on their ability to meet the unique needs of this age group.

Initiated in 1971, the Child Development Associate National Credentialing Program is a major national effort to evaluate and improve the skills of caregivers in center-based, family day care, and home visitor programs. A Child Development Associate is a person who has demonstrated competence in caring for young children during an assessment conducted by the CDA National Credentialing Program. Competent caregivers are awarded the Child Development Associate credential. An optional bilingual specialization is available to candidates working in bilingual (Spanish/English) programs. More than 17,000 child care providers have earned the CDA credential since 1975, and more than half of the States have incorporated the credential in child care licensing requirements.

Although training is not a requirement for the CDA assessment, the majority of candidates enroll in child development courses to increase their knowledge and understanding and, in part, as preparation for CDA assessment.

Therefore, HDS wants to stimulate two-year community colleges to train child care providers based on the CDA competencies and to prepare these candidates for the successful completion of the assessment process and award of the credential by the CDA national body.

Applicants will be expected to initiate new or adapt their current curriculum for caregivers of infants and toddlers (0–3 years); and/or of preschool age children (3–5 years); Family Day Care providers; and Home Visitors to meet specific requirements for CDA training for this child care population. Information about these requirements is available from the Council for Early Childhood Professional Recognition, National Association for the Education of Young Children, 1341 G Street NW., Suite 802, Washington, DC 20005. The toll-free telephone number is 800–424–4310.

Applications should describe proposed efforts to disseminate findings at local and State levels and participate in two meetings in Washington, DC, of all successful applicants under this priority area.

Eligibility under this priority area is restricted to two-year community colleges with prior involvement in training in the area of early childhood education or child care. Four-year institutions with prior involvement in such training and located in areas where a community college system does not exist are eligible to apply.

HDS anticipates funding 17-month projects having a Federal share not to exceed $49,500 per project. The budgets should include the expenses for one individual to participate in two meetings in Washington, DC, and the cost of CDA application, assessment and credential award for a minimum of 15 successful candidates.

5.2.B: Child Abuse and Neglect Interdisciplinary Training

Reports of child abuse and neglect have increased steadily since 1974 when data on official reports were first available. In 1984 more than 1.7 million children were reported to child protective service agencies because of suspected abuse or neglect. Recent data indicate that reporting rates are increasing by about 11% annually, with

the greatest increase, 35%, seen in child sexual abuse.

While the public's expectations of those charged with providing protective services are very high, the increased demand for services and the complexity of the issues involved strain the capacity of child protective agencies. For example, the basic conflict inherent in the goal of protecting children while not unnecessarily disrupting families continues to persist. In addition, workers are continually confronted with the difficult task of determining whether abuse has taken place, assessing the potential for further abuse or progress in treatment, and deciding whether or not to remove the child from the home or to return the removed child to the family.

The field of child abuse has increasingly required a multidisciplinary response, involving social work, pediatrics, law, psychology, psychiatry, nursing, education, public health, as well as other disciplines.

Despite these high expectations and the increased complexity of service issues, few workers enter protective services with the professional training and preparation to carry out this complex and demanding job and many professionals in related fields, who are called upon in child abuse cases, have had only superficial exposure to the problem of child abuse. Training programs have not kept pace with the demand for expertise. While some preservice and in-service training programs have been and are being developed for professionals entering the field, few inter-disciplinary academic programs exist which provide the comprehensive professional training which is needed.

The purpose of this priority area is to provide grants to approximately 10 institutions of higher education to establish interdisciplinary training programs which will enable graduate students in a number of academic disciplines to specialize in treatment of child abuse and neglect. These trainees are expected to provide leadership in administration, clinical practice, policy formulation and research in the field of child abuse.

Interdisciplinary training programs are expected to provide graduate level students who have developed skill and competence in a single discipline with the opportunity to learn the vocabulary, concepts, tools and perspectives of other disciplines through interdisciplinary coursework and clinical experiences. Interdisciplinary training builds on expertise in one discipline and enables the professional to understand the contributions of other disciplines and how that information can influence the professional's own discipline. Training programs to be established through this announcement will enable schools to apply interdisciplinary training methods to students who will concentrate on child abuse and neglect prevention, identification, diagnosis and treatment.

Grants will be awarded in two phases. The first phase will consist of small grant awards ($10,000 for 4 months) to several institutions of higher education for the purpose of evaluating the feasibility of establishing a child abuse interdisciplinary training program. The second phase will consist of 3-year competitive grants which will be awarded to applicants which have completed the feasibility study and submit successful applications for funds to establish a training program.

In phase one, HDS is interested in applications from institutions of higher education which seek to determine the feasibility of establishing a graduate level child abuse training program for professionals in several disciplines. All training programs must at a minimum, include the departments of social work, psychology and medicine. Programs which include other relevant disciplines or departments (e.g. pediatrics, criminal justice, neurology, nursing, psychiatry, law, education, public health) are encouraged. Any single department may apply for a feasibility study grant in phase one, although only one will be awarded per institution.

Applicants for grants in Phase I should describe in detail existing resources that could potentially become part of the newly established interdisciplinary training program in child abuse. Resources may include: Current faculty expertise in research, teaching or clinical aspects of child abuse and neglect, including child sexual abuse; courses in various departments which focus on child abuse or include significant components focusing on child abuse; clinical facilities which are currently being used in diagnosis or treatment of child abuse; existing interdisciplinary training program involving a minimum of three academic departments or disciplines; existing agreements with community agencies for the purpose of providing child abuse and neglect services, training of staff, practicum or clinical placements or other relevant activity; and any other resources.

Applicants should also describe any components of the program that would require significant developmental effort. Applications should include the intended organizational structure and the relation of the program to the specific departments and within the university. Applicants are encouraged to involve community agencies, clinical or teaching facilities, or academic departments in Phase I proposals.

Activities to be conducted under the feasibility study grant should include at least the following:

- Design of administrative and organizational aspects of the interdisciplinary training program and its relation to specific departments and within the institution.
- Development of formal agreements among academic departments concerning the establishment of an interdisciplinary training program at the graduate level and commitments from the various departments regarding their level of support (e.g. faculty, and other resources).
- Development of agreements with relevant community agencies regarding practicum or other clinical experiences (e.g. child welfare agencies, hospitals, mental health clinics, prosecutors' offices and police departments).
- Development of the interdisciplinary core curriculum in child abuse that includes both didactic and clinical components. Existing courses which can be adapted or designated to be part of the curriculum and courses which need to be developed should be identified. (Courses should provide opportunities for training in interdisciplinary perspectives.) Interdisciplinary clinical experiences which represent state of the art practice should be identified.
- Identification and definition of specific discipline and interdisciplinary competencies which students who participate will acquire.
- Development of guidelines for selection of students from various departments to participate in the program.
- Identification of non-Federal sources of support for activities of the program.

Upon completion of the feasibility study (4 months after the grant award) all grantees must submit a report describing the outcome of the grant. Immediately following the Phase I grant, any institution which determines that it is feasible, may submit an application (Phase II) for a 3 year grant to establish an interdisciplinary training program. Federal funding for each program shall not exceed $150,000 per year; up to $30,000 of this amount may be used by the institution for stipends to support students from the various participating departments.

These funds (except for stipends) are intended to support core administrative activities for the development and operation of the interdisciplinary

didactic and clinical programs. Since the purpose of these grants is training, indirect cost rates shall not exceed 8%. Applicants are encouraged to exceed the non-Federal funds cost-sharing requirement of one dollar for every three dollars of Federal funds requested.

Topic 3: Child Welfare Services Training

Introduction

The need for adequately trained and skilled staff is crucial to the delivery of high quality, cost-effective public child welfare services. This is particularly true as the child welfare field increasingly is involved with an older, more handicapped and more difficult population of children and their families. Yet the most recently available data indicate that the vast majority of individuals who are employed in public child welfare lack the professional preparation which would equip them to perform this demanding work.

The social work profession has historically taken a lead role in the professional preparation of child welfare workers. However, as the field and the profession have evolved, fewer graduates of social work programs have taken positions in public agencies and some agencies have either been unable to find qualified persons to fill positions or have declassified positions and have hired individuals with no professional credentials. The combination of these and other factors has created a critical problem in child welfare service delivery.

The child welfare training priority areas described below are intended to address this critical problem, promote effective collaboration between schools of social work and public child welfare agencies and expand the number of professionally trained and qualified individuals who provide services in the public child welfare system.

Applications will be considered from institutions of higher education which are accredited by the appropriate accrediting authority and which train bachelors or master level students in social work.

Applications are sought in four priorities: (1) Traineeships for students pursuing degrees in social work; (2) in-service training for persons employed in the field of child welfare; (3) demonstration projects which involve collaborative efforts between schools of social work and public child welfare agencies; and, (4) special grants which focus on the needs of Indians.

Institutions may apply for traineeship grants and one other type of grant.

5.3.A: Traineeships

Traineeship grants will provide financial support for the education and professional training of students pursuing undergraduate or graduate social work degrees who have a stated interest in practice in public child welfare after graduation. Traineeships are intended to support the education of professionals who will assume leadership positions in the field of public child welfare. All traineeships must include a field placement component that provides the student with direct experience in a child welfare related setting, preferably in the public sector. HDS is especially interested in proposals for traineeships for minority students.

Applicants are encouraged to seek cooperative agreements with public child welfare agencies in order to provide traineeships to public agency employees who demonstrate potential for leadership in child welfare and who wish to return to school to obtain an undergraduate or graduate level degree in social work.

Applications should describe the curriculum utilized and how it relates to the needs of child welfare practitioners.

Traineeship grants may only be used for student financial support and not for any other direct or indirect costs for the applicant institution.

Traineeship grants will be awarded for up to 24 months, for a maximum of five stipends per school, not to exceed a Federal share of $25,000 per school, per year.

5.3.B: In-Service Training

In-Service Training grants will support training projects from institutions of higher education for personnel employed in public child welfare agencies. Topics for training should address specific high priority training needs identified by the public agency and may focus on any level of personnel, including front line workers, supervisors or administrators.

The training program should be described in detail with specific measurable outcomes and a plan for evaluation of effectiveness. Applicants must show that public child welfare agencies have actively participated in the selection of training topics and in the planning and implementation of the project. Participating agencies are encouraged to contribute resources toward the completion of the project goals.

HDS anticipates funding 17 month In-Service Training grants having a Federal share not to exceed $100,000 per grant.

5.3.C: Collaboration between Schools and Agencies

Grants will be awarded in this area to support special projects from institutions of higher education which will demonstrate significant collaboration between schools of social work and public child welfare agencies in order to accomplish specific training objectives. These collaborative efforts may also include professional associations with significant involvement in public child welfare. (Projects which are primarily in-service training or traineeships will not be funded under this priority area.)

Collaborative projects may include: (a) Development of a practice model and curriculum that prepare students for practice and for leadership in public child welfare; (b) Demonstration of a model to share or exchange staff and faculty in order to make curriculum more experience based and enable agencies to benefit from expertise of faculty; (c) Efforts to promote upgrading of State and/or local merit system procedures for classifying professional social work positions; (d) Efforts to define entry level competencies needed for persons to enter child welfare practice and develop a model curriculum which provides training in those competency skills; (e) Definition of competencies for supervisors in child welfare practice and development of a curriculum which prepares personnel for supervisory work; (f) Efforts involving professional social work organizations, schools and agencies in addressing recruitment and retention problems in public child welfare practice; (g) Efforts to improve the extent to which interdisciplinary services are provided to child welfare clients; (h) Definition of competencies needed for child protective services practice and the development of a curriculum which provides training in those competency skills.

HDS anticipates funding 17 month collaborative grants having a Federal share not to exceed $150,000 per grant.

5.3.D: Special Indian Grants

Special grants which focus on the education and training of Indians will be awarded in each of the three Child Welfare Services Training priority areas described above.

Section 6: Transfer of International Innovations

While this country is a natural field for research and demonstration in the area of social services, we can still gain insight from other countries. Knowledge of social services in other countries, the programs, authorizations and governance, delivery systems and innovations can be beneficial to U.S. domestic programs. HDS seeks proposals which address the transfer of innovations from other countries.

The following factors should be considered in proposing a transfer of an innovation from another country:

- Promise of contributing significantly to the achievement of one or more of the major HDS goals cited in the Preamble to this announcement and be of benefit to one or more of the HDS target groups which include Native Americans, the socially and economically needy elderly, the developmentally disabled or at-risk children, youth and families.
- Be relevant to domestic research with the possibility of complementing ongoing or new U.S. projects.
- Relate to the U.S. commitment to its participation in international organizations, both governmental and non-governmental, and to United Nations-sponsored events, such as the International Youth Year 1985; follow-up to the World Assembly on Aging; and the United Nations' Decade of Disabled Persons.

Examples of areas which HDS will consider are: access to services by the handicapped; children and youth at-risk; community and in-home services for functionally impaired populations; projects which strengthen community and family based systems of services for older persons; innovative housing arrangements for the aged; intergenerational linkages; programs designed to reduce dependency, including work-related day care; self-help; strategies for strengthening families; social indicators; and social service coordination and management systems.

Federal funds awarded under this priority area cannot be used to support international travel. However, a portion of the non-Federal contribution from cooperating organizations may be utilized for international travel.

There are no eligibility restrictions for applications in this priority area. However, HDS is interested in innovative models and is not interested in funding ongoing direct service projects which have been imported to the U.S. or exported to another country.

Part III—Application Process

A. Eligible Applicants

In general, any State, public or private nonprofit organization, institution or agency may submit an application under this announcement. Individuals are not eligible to apply.

Some priority areas or topics included in this announcement may have more restrictive eligibility requirements. Where limitations exist, the eligible entities are identified in the priority area description. Applications from organizations that do not meet the eligibility restrictions in the priority area description will not be reviewed.

We encourage applications that are developed jointly by State, local and community-based social services agencies, foundations or universities, since this helps to coordinate local resources. For these applications, a lead organization must be identified, and that organization must be an eligible applicant.

For-profit organizations may be eligible for certain projects funded under the authority of the Head Start Act, Native Americans Program Act, Runaway and Homeless Youth Act and, in limited cases, the Older Americans Act. The priority area descriptions in this announcement identify those priority areas under which for-profit organizations may submit applications. For-profit organizations may also participate as contractors under grants to eligible applicants on all projects.

Except in those instances where eligibility is not restricted to non-profit organizations, all applicants which have not previously received HDS program support must reference their listing in the IRS's most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code or submit proof of non-profit status (e.g., a 501(c)(3) letter from IRS). HDS cannot fund a non-profit applicant without acceptable proof of its status.

B. Available Funds

The availability of funds for FY 1987 and FY 1988 is dependent on passage of appropriations by the Congress. Based on the level of funding for FY 1986, HDS expects to award new grants and cooperative agreements during the fourth quarter of FY 1987. Subject to Congressional action on the FY 1987 budget, HDS may also award a number of grants under this announcement in the first and second quarters of FY 1988. Appropriate HDS discretionary funding authorities will be used to fund projects, and more than one authority may be used to fund some projects.

HDS expects to make approximately 300 new awards pursuant to this announcement. These awards may range from $10,000 to a maximum of $200,000 per budget period (except where noted in the priority area descriptions), with an average award of $100,000. Actual awards may vary widely and eligible applicants requesting smaller awards (or awards for projects of less than 12 months duration) are encouraged to apply.

Applicants should be aware that HDS receives 2,000 to 3,000 applications annually to its Coordinated Discretionary Funds Program. Of these, about 200 to 400 applicants receive grant awards each year.

C. Grantee Share of the Project

Under the Coordinated Discretionary Funds Program, HDS does not make grant awards for the entire project cost (with the exceptions described below). Successful applicants are eligible to receive $3 in Federal funding for each $1 secured from non-Federal sources, up to the limits specified in the priority area descriptions in this announcement. There is, however, a programmatic exception under this year's CDP. For applications under priority areas described in section 4 of Part II of this announcement, "Research and Evaluation," non-Federal funds must comprise at least 5 percent of the total project cost.

At least 25% of the total cost for each budget period of proposed projects must come from a source other than the Federal government (one dollar match for every three dollars requested from HDS) with two exceptions. The first relates to tribal organizations or projects funded under the Native Americans Act, where the grantee match must be 20% of the total cost of the proposed project (one dollar match for every four dollars requested from HDS). Tribal organizations may also include in their applications a request to the Administration for Native Americans for a waiver of the non-Federal cost-sharing requirement for the project. Such requests will be dealt with on a case-by-case basis according to applicable laws and regulations.

The second exception relates to applications originating from American Samoa, Guam, the Virgin Islands or the Northern Mariana Islands. Applicants from these territories are covered by section 510(d) of Pub. L. 95–134, which requires the Department to waive "any requirement for local matching funds under $200,000" for these territories.

There is a change in this year's Coordinated Discretionary Funds Program regarding universities or other non-profit organizations which had institutional cost sharing agreements with HHS and which propose to carry out research projects. Previously, the provisions of the institutional cost-sharing agreement took precedence over the "$3 Federal/$1 non-Federal" matching or project cost-sharing requirement. This is no longer true since Department-wide institutional cost-sharing agreements are no longer negotiated or approved. Therefore, project-by-project cost-sharing will be required for grants under the Fiscal Year

1987 Coordinated Discretionary Funds Program.

The non-Federal share of total project costs for each budget period may be in the form of grantee-incurred costs or third party in-kind contributions. HDS strongly encourages applicants to propose a grantee share which is more than 25% of the project costs. HDS also encourages applications where the matching requirement will be met in cash (as opposed to in-kind contributions) from non-Federal funding sources.

If the required non-Federal share is not met by a funded project, HDS will disallow any unmatched Federal dollars.

D. Application Process

1. Availability of Forms

All instructions and forms required for submittal of applications are included in this announcement. Additional copies of this announcement may be obtained by writing or telephoning:

HDS/Division of Research and Demonstration
200 Independence Avenue SW., HHH Building,
Room 724–F
Washington, DC 20201
Attention HDS–87–1
Telephone: (202) 755–4633.

This program announcement is also available as an electronic document through the HDS Computer Bulletin Board. Organizations equipped with computers and modems may link to the bulletin board by calling (202) 755–1642. We suggest that organizations use communications software that supports the xmodem file transfer protocol, and IBM PC compatibility is recommended. Communications parameters are no parity, 8 data bits and 1 stop bit. The HDS bulletin board runs at 1200 bits per second (1200 baud).

2. Application Submission

One signed original and two copies of the application must be submitted to:

Department of Health and Human Services
HDS/Division of Grants and Contracts Management
200 Independence Avenue SW., HHH Building,
Room 724–F
Washington, DC 20201
Attention HDS–87–1

Priority Area: _____

3. Notification Under Executive Order 12372

This program is covered under Executive Order 12372 "Intergovernmental Review of Federal Programs" and 45 CFR Part 100 "Intergovernmental Review of Department of Health and Human Services Programs and Activities." Under the Order, States may design their own processes for reviewing and commenting on proposed Federal assistance under covered programs.

All States and territories except Alaska, Idaho, Nebraska, American Samoa and Palau have elected to participate in the Executive Order process and have established Single Points of Contact (SPOCs). Applicants from these areas need take no action regarding E.O. 12372. Applications for projects to be administered by Federally-recognized Indian tribes are also exempt from the requirements of E.O. 12372. Applications which propose exclusively to use funds administered by the Administration on Aging, and which are, therefore, not covered by under E.O. 12372, will not be subject to the "accommodate or explain" rule of the Order. Applicants should contact their SPOCs as soon as possible to alert them to the prospective application and to receive any necessary instructions.

Applicants must submit any required material as early as possible so the program office can obtain and review SPOC comments as part of the award process. It is imperative that the applicant submit all required materials, if any, to the SPOC and indicate the date of this submittal (or date of contact if no submittal is required) on the SF 424, item 22a.

SPOCs have sixty (60) days starting from the application deadline to comment on applications for financial assistance under this program. Comments are, therefore, due no later than February 15, 1987.

SPOCs are encouraged to eliminate the submission of routine endorsements as official recommendations. Additionally, SPOCs are requested clearly to differentiate between mere advisory comments and those official State process recommendations which they intend to trigger the "accommodate or explain" rule.

When comments are submitted directly to HDS, they should be addressed to:

Department of Health and Human Services,
HDS/Division of Research and Demonstration,
200 Independence Avenue SW., HHH Building,
Room 724–F,
Washington, DC 20201, attn: HDS–87–1

Priority Area: _____

A list of the State Single Points of Contact is included at the end of this announcement.

4. Notification of State Developmental Disabilities Councils

A copy of the application must be submitted to the State Developmental Disabilities Council for its review and comment when individuals with developmental disabilities who reside in that State are included as a target population of the proposed project. A listing of the Councils may be obtained by calling (202) 755–4633. This requirement is in addition to the SPOC notification required by E.O. 12372.

5. Application Consideration

Applications that conform to the requirements of this program announcement will be reviewed and scored competitively against the evaluation criteria specified in Part III, Section F.2 of this announcement and evaluated by Federal officials and qualified persons from outside of the Federal government. Although the results of this review are a primary factor considered in making the decision about an application, review scores are not the only factor.

HDS also solicits comments from other Federal Departments, from Federal Regional Office staff, from interested foundations, national organizations, specialists, experts, States and the general public. These comments, along with such other factors as the geographic distribution of funding and the compatibility of applications with HDS priorities, will be considered by the Assistant Secretary for Human Development Services and HDS Senior Staff in making funding decisions.

The Older Americans Act places certain responsibilities upon, and authority in, the Commissioner on Aging which affects the role of the Administration on Aging in implementing this program announcement. All such requirements will be met through actions which conform to the mandates of the Act. Only the Commissioner on Aging has the authority to approve applications for funding under Title IV of the Older Americans Act.

HDS reserves the option of discussing applications with, or referring them to, other Federal or non-Federal funding sources when this is determined to be in the best interest of the Federal government or the applicant.

6. Funding Limitations on Indirect Costs

Applicants should be aware that for training projects there is a limitation on

indirect costs to eight percent of the total allowable direct costs or, where a current agreement exists, the organization's negotiated indirect cost rate, whichever is lower. For all other applicants, indirect costs may be requested only if the applicant has (or will obtain) a negotiated indirect cost rate with the Department's Division of Cost Allocation or with another Federal agency. Local government agencies (other than local education agencies) are not required to submit their indirect cost proposals unless requested by HDS.

7. Budget Expressed in Total Project Costs (Federal Plus Non-Federal)

There will be a change this year in the manner in which the project budget is presented. In prior years, we had requested budgets for Federal funds only. This year we are requesting a consolidated budget, showing a total of both Federal and non-Federal share. This will be explained further in Part IV. Our award documents will also reflect this change.

E. Special Considerations for Funding

Within the limits of available Federal funds, HDS makes financial assistance awards consistent with the purposes of the statutory authorities governing the HDS Coordinated Discretionary Funds Program and this announcement. In making these decisions, preference will be given to applications which feature: a substantial innovation that has the potential to improve theory or practice in the field of human services; a model practice or set of procedures that hold the potential for dissemination to, and utilization by, organizations involved in the administration or delivery of human services; substantial involvement of volunteers; substantial involvement (either financial or programmatic) of the private sector; a favorable balance between Federal and non-Federal funds available for the proposed project; the possibility of a large degree of benefit for a small Federal investment; a programmatic focus on those most in need; and substantial involvement in the proposed project by national or community foundations.

To the extent possible, final decisions will reflect the equitable distribution of assistance among the States, geographical areas of the nation, rural and urban areas, and ethnic populations. HDS Senior Staff also take into account the need to avoid wasteful duplication of effort in making funding decisions.

F. Criteria for Screening and Review

All applications that meet the deadline will be screened to determine completeness and conformity to the requirements of this announcement. Complete, conforming applications will then be reviewed and scored competitively.

1. Screening Requirements

In order for an application to be in conformance, it must meet both of the following requirements:

(a) Number of copies: An original signed application, with the signature appearing on Standard Form 424 (published at the end of this announcement) and two copies must be submitted.

(b) Length: The narrative portion of the application *must not exceed twenty double-spaced pages* (or ten single-spaced pages) typewritten on one side of the paper only. The capability statement must not exceed two double-spaced pages or one single-spaced typewritten page.

UNDER NO CIRCUMSTANCES WILL APPLICATIONS THAT DO NOT MEET THESE SCREENING REQUIREMENTS BE REFERRED TO REVIEW PANELS.

2. Evaluation Criteria

Applications which pass the screening will be reviewed by at least three individuals. These reviewers will be primarily experts from outside the Federal government. Reviewers will score the applications, basing their scoring decisions on the following criteria:

(a) Need for the Project: 20 points.

The application clearly describes, in concrete terms, the social problem or situation that prompts the applicant to propose a project. The need for the project is discussed in terms of local, regional or national significance and the importance of the issues to be addressed. It also describes how the proposed project builds upon previous work, how it advances the state of knowledge from a national perspective and how it addresses a priority need identified in this announcement.

(b) Project Methodology: 20 points.

The application describes specific plans for conducting the project in terms of the tasks to be performed. It includes relevant information about: (1) hypotheses to be tested (if appropriate); (2) goals and measurable objectives; (3) what the project will do; (4) how the project will be conducted; (5) data to be collected (including specification of data sources); (6) plan for data analysis; and (7) chart with tasks laid out over time (Gantt chart). A detailed discussion is provided on how the approach proposed will accomplish the project objectives. Whenever possible, innovative use should be made of volunteers and the private sector should be involved.

(c) Expected Outcomes: 20 points.

The proposed project will result in a measurable, concrete reduction of a significant problem. The anticipated results and products are specified and the expected benefits for HDS target groups and human service providers are delineated. Outcomes as opposed to process measures are emphasized.

Where appropriate, evaluation plans and procedures should be described in detail and should be capable of measuring the degree to which project objectives have been accomplished.

(d) Dissemination and Utilization: 20 points.

The application describes the methods the project will use to share its experiences and findings in the field of human services in general and specifically with agencies and organizations capable of developing improved service delivery and management. The steps to be taken to disseminate and promote the utilization of project products and findings, and the Federal and non-Federal resources required, are described. The specific audiences to which the products will be addressed should be identified.

(e) Level of Effort: 20 points.

The resources that will be needed to conduct the project are specified, including personnel, time, funds and facilities. These resources should be adequate to meet the work plan described in the application. The staff (or other personnel resources) should be qualified and the team has the variety of skills required and ability to produce final results that are readily comprehensible and usable. The staffing pattern clearly links responsibilities to project tasks. The total cost of the project is reasonable in view of anticipated results. Any collaborative effort with other agencies or organizations is clearly identified and written assurances referenced. A description by category (personnel, travel, etc.) of the total funds required and of the sources of outside support that will be used to meet the matching requirement is included. The funds (total of Federal funds and non-Federal funds) are specified for each budget period.

These evaluation criteria correspond to the outline for the narrative section of the application and the descriptions of the five criteria above should be used in developing the program narrative.

G. Closing Date for Receipt of Applications

The closing date for submittal of applications under this program

announcement is December 15, 1986.
Applications must be mailed or hand-delivered to:
HDS/Division of Grants and Contracts Management,
200 Independence Avenue SW., HHH Building, Room 724–F,
Washington, DC 20201,
Attention HDS–87–1

Priority Area: _____

Hand-delivered applications are accepted during the normal working hours of 9:00 a.m. to 5:30 p.m., Monday through Friday. An application will be considered as meeting the deadline if it is either:

1. Received on or before the deadline date at the above address; or

2. Sent on or before the deadline date and received in time to be considered during the competitive review and evaluation process. Applicants are cautioned to request a legibly dated U.S. Postal Service postmark or to obtain a legibly dated receipt from a commercial carrier or the U.S. Postal Service. Private metered postmarks are not acceptable as proof of timely mailing.

Applications which do not meet the above criteria are considered late applications. HDS will notify each late applicant that its application will not be considered in the current competition.

HDS may extend the deadline for all applicants because of acts of God, such as floods, hurricanes or earthquakes, when there is widespread disruption of the mails or when HDS determines an extension to be in the best interest of the government. However, if HDS does not extend the deadline for all applicants, it may not waive or extend the deadline for any applicant(s).

Part IV—Instructions for Completing Applications

A. Application Package

In order to expedite the processing of applications, we request that you *adhere to the following instructions explicitly.* Each application submission must include:

1. An original and two copies of the application (see Section B below). Each copy should be stapled securely (front and back if necessary) in the upper left corner. The original copy of the application must have an original signature in item 23 on page 1 of the SF 424. In order to facilitate handling, please do not use covers, binders or tabs. Do not include extraneous materials such as agency promotion brochures, slides, tapes, film clips, etc. It is not feasible to use such items in the review process, and they will be discarded if included.

2. Do not include a self-addressed, stamped acknowledgment card. All applicants will be automatically notified of receipt and of the identification number assigned to their application. This number and the priority area must be referred to in *ALL* subsequent communication with HDS concerning the application. If acknowledgment is not received within ten weeks after the deadline date, please notify HDS by telephone (202) 755–4633.

After an identification number is assigned and the applicant has been notified of the number, applications are filed numerically by identification number to aid in quick retrieval. It will not be possible for HDS staff to provide a timely response to inquiries about a specific application unless the identification number and the priority area are given.

Applicants should be advised that HDS staff can not release pre-decisional information relative to an application other than that it has been received and that it is going through the review process. Unnecessary inquiries delay the award process. Once a decision is reached, the applicant will be notified as soon as possible of the acceptance or rejection of the application.

B. Content of Application

Each copy of the application *must* contain an SF 424, completed and assembled in accordance with the following instructions:

1. Page 1, the cover page of the application;

2. Part II, Project Approval Information;

3. Part III, Budget Information, Section B (Budget Categories) and Section E (Budget Estimates for Federal Funds Needed for Balance of the Project);

4. Summary description with listing of key words;

5. Part IV, Program Narrative, which should be no more than twenty double-spaced or ten single-spaced pages and typewritten on one side of the paper only. In addition, an organizational capability statement, no more than two double-spaced typewritten pages or one single-spaced page, should be included;

6. Part V, Assurances; and,

7. Letters which show collaboration or substantive commitment to the project by organizations other than the applicant organization are not part of the narrative and, therefore, are not counted against the twenty page limit for the narrative.

C. Preparing the Application

The SF 424 has been reprinted for your convenience. We suggest that you reproduce it and type your application on the copy. Prepare your application in accordance with the following instructions:

1. *SF 424, page 1:* Complete item numbers 4, 5, 6b, 7, 8, 10, 12, 13, 15, 16, 22 and 23 only. Specific instructions are as follows:

Top of page. Enter the number of the priority area under which the application is being submitted.

Item 1. Preprinted on the form.

Items 2–3. Leave blank.

Item 4.a. Enter the name of applicant organization. Do not include the name of the principal investigator or project director on this line.

Item 4.b. Enter the unit within the organization that will actually carry out the project. If 4.a and 4.b are the same, leave 4.b blank.

Items 4.c.–4.g. Self explanatory.

Item 4.h. Enter the name and telephone number of a person who can respond to questions about the application.

Item 5. Enter the employer identification number of the applicant organization as assigned by the Internal Revenue Service.

Item 6.a. Leave blank.

Item 6.b. Enter the number of the priority area under which the application is being submitted. If more than one priority area is listed, HDS will disregard all but the first one listed.

Item 7. The title should be no more than 200 characters long, including spaces and punctuation. It should be typed in four lines of 50 characters each.

Summary Description. Item 7 also asks for a summary description of the project using Section IV. In place of Section IV, use a separate sheet of 8½ x 11 plain paper to provide this summary description of the project. Clearly mark this separate page with the applicant name as shown in item 4.a and the priority area as shown in item 6.b. The summary description should not exceed 1,200 characters, including words, spaces and punctuation. These 1,200 characters become part of the computer data base on each project.

The description should be specific and concise. It should describe the objectives of the project, the approaches to be used and the outcomes expected. At the end of the summary, list major products that will result from the proposed project (such as software packages, materials, management procedures, data collection instruments, training packages or videos). Remember, this summary description is limited to 1,200 characters. This information, in conjunction with the information on the SF 424, becomes the project's "abstract"

and will be the major source of information about the proposed project.

At the bottom of the page, but apart from the summary description of the project, type up to 10 key words describing the service(s) and target population(s) to be covered by the proposed project. The key words are to be selected from the list at the end of Part IV of this announcement. These key words will be used for computer searches for specific types of proposed and funded projects.

Item 8. Self-explanatory with the exception of 8.e, "City", which includes a town, township, or other municipality.

Item 9. Leave blank.

Item 10. Enter specific number of persons to be directly benefited or served during the life of the project. This number should be substantiated in the application's Program Narrative.

Item 11. Leave blank.

Items 12.a—12.f. Enter the budget for (1) the total period of 17 months or less or (2) the first year if the proposed project exceeds 17 months. 12.a– Enter the amount of Federal funds requested. 12.b–12.e. Enter the amount(s) of funds from non-Federal sources that will be contributed to the proposed project for each budget period. These items (12.b–12.e) are considered cost-sharing or "matching funds". It is important that the dollar amounts entered in items 12.b to 12.e (the non-Federal share) total at least 25 percent of the total project cost for each budget period, except for: applications under Section 4, "Research and Evaluation," where the non-Federal share must be at least 5 percent of the total project cost; applications from American Native tribal organizations or projects funded under the Native Americans Act, where the non-Federal share must be 20 percent of the total project cost; and, applications originating from American Samoa, Guam or the Northern Mariana Islands, where non-Federal cost sharing is not required. In item 12.f, enter the sum of items 12.a–12.e.

Item 13.a. Enter the number of the Congressional district where the principal office is located.

Item 13.b. Enter the number of the Congressional districts(s) where the project will be located. If State-wide, a several state effort, or nationwide, enter "00".

Item 14. Leave blank.

Item 15. Enter the desirable start date for the project, beginning on or after July 1, 1987.

Item 16. Enter the estimated number of months to complete the project after Federal funds are available. Projects are generally for 12 months, 24 months or 36 months or for the duration specified in the priority area description.

Items 17.–21. Leave blank.

Item 22a. Enter the date the applicant contacted the Single Point of Contact (SPOC) regarding this application. Select the appropriate SPOC from the attached listing.

Item 22b. Check the appropriate box if not covered by E.O. 12372.

Items 23a. and b. Self-explanatory

Item 24–33. Leave blank.

2. *SF 424, Part II:* Negative answers will not require an explanation unless HDS requests more information at a later date. All "yes" answers must be explained on a separate page in accordance with these instructions.

Item 1. Provide the name of the governing body establishing the priority system and the priority rating assigned to this project. If the priority rating is not available, give the approximate date that it will be obtained.

Item 2. Provide the name of the agency or board which issued the clearance and attach the documentation of status or approval. If the clearance is not available, give the approximate date that it will be obtained.

Item 3. Furnish the name of the approving agency and the approval date. If the approval has not been received, state approximately when it will be obtained.

Item 4. Show whether the approved comprehensive plan is State, local or regional; or, if none of these, explain the scope of the plan. Give the location where the approved plan is available for examination, and state whether this project is in conformance with the plan. If the plan is not available, explain why.

Item 5. Show the population residing or working on the Federal installation who will benefit from this project. Federally recognized Indian reservations are not "Federal installations."

Item 6. Show the percentage of the project work that will be conducted on Federally-owned land or leased land. Give the name of the Federal installation and its location.

Item 7. Briefly describe the possible beneficial and/or harmful effect on the environment because of the proposed project. If an adverse environmental effect is anticipated, explain what action will be taken to minimize it.

Item 8. State the number of individuals, families, businesses or farms this project will displace.

Item 9. Show the Catalog of Federal Domestic Assistance number, the program number, the type of assistance, the status, the amount of each project where there is related previous, pending or anticipated assistance from another funding source.

3. *SF 424, Part III—Budget Information:* We have deleted Sections A, C, D and F under Part III. Sections B and E have been reprinted at the end of the announcement.

a. Section B—Budget Categories

This budget which includes the Federal as well as non-Federal funding for the proposed project covers (1) the total project period of 17 months or less or (2) the first year if the proposed project exceeds 17 months. It should relate to item 12.f, total funding, on the SF 424, page 1. The amount of Federal funds alone requested for the second or third year of a project is to be specified in Part III, Section E, Budget Estimate of Federal Funds Needed for Balance of Project.

Under the column title "Total," enter under column (5) the total requirements for funds (both Federal and non-Federal for the total project period if the project will be completed in 17 months or less, or for the first year if the proposed project exceeds 17 months) by object class category and the total funds required for the proposed project. A budget justification should be included when it is necessary to explain fully and justify major items, as indicated below. The budget justification should not exceed three typed pages and should follow the page with Sections B and E on it.

Personnel—Line 6a: Enter the total costs of salaries and wages of applicant/grantee staff. Identify the principal investigator or project director, if known. Specify the percentage of time and titles of the organization's staff who will be working on the project as part of the budget justification. Do not include costs of consultants or personnel costs of delegate agencies.

Fringe Benefits—Line 6b: Enter the total costs of fringe benefits unless treated as part of an approved indirect cost rate. Provide a break-down of amounts and percentages that comprise fringe benefit costs.

Travel—6c: Enter total costs of out-of-town travel (travel requiring per diem) for staff of the project. Do not enter costs for consultant's travel or local transportation. Provide justification for requested travel costs. Include the total number of trips, destinations, length of stay, transportation costs and subsistence allowances.

Equipment—Line 6d: Enter the total costs of all equipment to be acquired by the project. "Equipment" is non-expendable tangible personal property having a useful life of more than two

years and an acquisition cost of $500 or more per unit. An applicant may use its own definition, provided that it would at least include all non-expendable tangible personal property as defined in the preceding sentence.

Supplies—Line 6e: Enter the total costs of all tangible expendable personal property (supplies) other than those included on line 6d.

Contractual—Line 6f: Enter the total costs of all contracts, including (1) procurement contracts (except those which belong on other lines such as equipment, supplies, etc.) and, (2) contracts with secondary recipient organizations including delegate agencies. Also include any contracts with organizations for the provision of technical assistance. Do not include payments to individuals on this line. Attach a list of contractors indicating the name of the organization, the purpose of the contract and the estimated dollar amount of the award. If the name of contractor, scope of work and estimated total is not available or has not been negotiated, include in Line h, "Other."

Whenever the applicant/grantee intends to delegate part or all of the program to another agency, the applicant/grantee must complete this section (Section B, Budget Categories) for each delegate agency by agency title, along with the supporting information. The total cost of all such agencies will be part of the amount shown on Line 6f. Provide back-up documentation identifying the name of contractor, purpose of contract and major cost elements.

Construction—Line 6g: Enter the costs of renovation or repair. Provide narrative justification and break-down of costs. New construction is not allowable unless specifically provided for in the HDS program legislation; Federal funds are rarely used for either renovation or repair.

Other—Line 6h: Enter the total of all other costs. Such costs, where applicable, may include, but are not limited to, insurance, medical and dental costs, noncontractual fees and travel paid directly to individual consultants, local transportation (all travel which does not require per diem is considered local travel), space and equipment rentals, printing and publication, computer use, training costs including tuition and stipends, training service costs including wage payments to individuals and supportive service payments, and staff development costs.

Total Direct Charges—Line 6i: Show the totals of Lines 6a through 6h.

Indirect Charges—Line 6j: Enter the total amount of indirect costs. If no indirect costs are requested enter "none." This line should be used only when the applicant (except local governments) has a current indirect cost rate agreement approved by the Department of Health and Human Services or another Federal agency. Enclose a copy of this agreement. Local governments shall enter the amount of indirect costs determined in accordance with HHS requirements. In the case of training grants to other than State or local governments (as defined in 45 CFR Part 74), the reimbursement of indirect costs will be limited to the lesser of the negotiated or actual indirect cost rate or 8 percent of the amount allowed for direct costs exclusive of any equipment charges, rental of space, tuition and fees, post-doctoral training allowances, contractual items, and alterations and renovations. It should be noted that when an indirect cost rate is requested, these costs included in the indirect cost pool should not be also charged as direct costs to the grant.

Total—Line 6k: Enter the total amounts of Lines 6i and 6j.

Program Income—Line 7: Enter the estimated amount of income, if any, expected to be generated from this project. Do not add or subtract this amount from the total project amount. Describe the nature and source of income in the Program Narrative.

b. Section E—Budget Estimate of Federal Funds Needed for Balance of the Project

This section should only be completed if the total project period exceeds 17 months.

Totals—Line 20: Enter the estimated required *Federal* funds for the second budget period (months 13 through 24) under (b) first and for the third budget period (months 25 through 36) under (c) second opposite "Totals."

4. *SF 424, Part IV, Program Narrative:* Describe the project you propose in response to this announcement addressing the specific concerns mentioned under the priority area description in Part II. Your narrative (20 pages typed double-spaced, or ten pages typed single-spaced maximum, on 8½" K χ 11" plain white bond with 1" margins on both sides) should provide information on how the application meets the evaluation criteria in Part III. Reproductions of larger size paper, reduced to meet the size requirement, are not acceptable. We strongly recommend that you follow these format and page suggestions:

a. Need for the Project (5 pages double-spaced).

The application should clearly describe, in concrete terms, the social problem or situation that prompts the applicant to propose a project. The need for the project should be discussed in terms of local, regional or national significance and the importance of the issues to be addressed. It also should describe how the proposed project would build upon previous work, advance the state of knowledge from a national or regional perspective and address a priority need identified in this announcement.

b. Project Methodology (8 pages double-spaced)

The application should describe specific plans for conducting the project in terms of the tasks to be performed. It should include relevant information about: (1) Hypotheses to be tested (if appropriate); (2) concise and clear statement of goals and measurable objectives; (3) what the project will do; (4) how the project will be conducted; (5) data to be collected (including specification of data sources); (6) plan for data analysis; and (7) chart with tasks laid out over time (Gantt chart). A detailed discussion should be provided on how the approach proposed will accomplish the project objectives. Whenever possible, innovative use should be made of volunteers and the private sector should be involved.

c. Expected Outcomes (2 pages double spaced)

The program narrative should describe how the proposed project will result in a measurable, concrete reduction of a significant problem. The anticipated results and products should be specified and the expected benefits for HDS target groups and human service providers delineated. Outcomes as opposed to process measures should be emphasized.

Where appropriate, evaluation plans and procedures should be described in detail and should be capable of measuring the degree to which project objectives have been accomplished.

d. Dissemination and Utilization (2 pages double-spaced)

This section should describe the methods the project will use to share its experiences and findings in the field of human services in general and specifically with agencies and organizations capable of developing improved service delivery and management. The steps to be taken to disseminate and promote the utilization of project products and findings, and the Federal and non-Federal resources required, should be described. The specific audiences to which the products will be addressed should be identified.

e. Level of Effort: (3 pages doubled-spaced)

This portion of the program narrative should describe the resources that will be needed to conduct the project, including personnel, time, funds and facilities. The description should indicate that staff (of other personnel resources) are qualified and the team has the variety of skills required and ability to produce final results that are readily comprehensible and usable. The staffing pattern clearly should link responsibilities to project tasks. Costs should be justified as reasonable in view of anticipated results. Any collaborative effort with other agencies or organizations should be clearly identified and written assurances referenced. A description by category (personnel, travel, etc.) of the Federal funds required and of the sources of outside support that will be used to meet the matching requirement should be included.

5. *Organizational Capability Statement:* A brief (maximum 2 pages double-spaced or one page single-spaced) background description of how the applicant agency (or the particular division of a larger agency which will have responsibility for this project) is organized and the types and quantity of services it provides or research capabilities it possesses. This description should cover capabilities not included in the program narrative under level of effort. It may include descriptions of any current or previous relevant experience or describe the competence of the project team and its demonstrated ability to produce a final product that is readily comprehensible and usable. It may include a description of the qualifications of key staff described in a few paragraphs rather than in formal vitae.

6. *Part V, Assurances:* Applicants are required to file Part V, Assurances, and the Assurance of Compliance with the DHHS Regulations under Title VI of the Civil Rights Act of 1964 and the Assurance of Compliance with section 504 of the Rehabilitation Act of 1973, as amended. Copies of these assurances are reprinted at the end of this announcement.

D. Check List of Application Requirements

The following check list is provided for your convenience:

- ☐ SF 424 has been completed according to the instructions, signed and dated by an authorized official (item 23), and the original has been included in the package to be mailed along with the two copies.
- ☐ The original and both copies of the application have been stapled securely (no folders or binders) with the first page of the SF 424 as the first page of each copy of the application.

Included in your application package are:

- ☐ One original application plus two copies. The original and both copies of the application should include the following:
- ☐ SF 424, page 1 and Parts II and III;
- ☐ Summary description;
- ☐ SF 424, Part IV, Program narrative (20 pages, double-spaced maximum);
- ☐ Organizational capability statement (2 pages, double-spaced maximum); and,
- ☐ Part V, Assurances

The original application, the two copies of the application and the summary description should be packaged together so that they can be processed together.

Remember, applications must be postmarked or hand delivered (by 5:30 p.m.) no later than December 15, 1986 to:
HDS/Division of Research and Demonstration,
200 Independence Avenue SW., HHH Building, Room 724–F
Washington, DC 20201
Attention HDS–87–1

Priority Area

F. Points To Remember

• In computing the required match for all projects except those funded under the Native Americans Act Authority, proposals from certain U.S. Territories or applications under priority areas described in Section 4 of Part II of this announcement, "Research and Evaluation," please note that 25% of the *total* (the amount requested and your cost share) project cost is equivalent to ⅓ of the amount requested from HDS. Thus, for every 3 Federal dollars you request, you must match with one dollar from your organization or another source. An application may be unduly penalized in the review process by careless errors relating to the computation of the non-Federal share or match.

In order to compute the required minimum match, divide the amount you are requesting from HDS by 3. For example, if your request for Federal funds is $100,000, then the required minimum match or cost sharing is $33,333. The total project cost, Federal request and proposed matching cost, is $133,333.

• You are required to send an original and two copies of an application.

• Designate, at the top of the first page of the SF 424, your application for one priority area only.

• *Applications containing narratives in excess of twenty typewritten double-spaced pages (or ten typewritten single-spaced pages) or capability statements of more than two double-spaced pages (or 1 single-spaced page) will not be given further consideration.*

• The summary description of 1,200 characters or less is an essential element of the application. It is important that this accurately reflect the nature and scope of the proposed project.

• Follow the recommended format as closely as possible in preparing the program narrative. The format reflects the evaluative criteria which will be used by reviewers to evaluate applications.

• General support letters endorsing the project are *not* to be included.

• The qualifications of key staff should be described in a few paragraphs rather than in formal vitae. Unless specifically requested under a priority area, vitae or resumes are not to be provided and will not be included in the applications provided to reviewers.

• Although multiple applications (of different concepts) from the same applicant are not prohibited, they are not encouraged.

• Indirect costs of training grants may not exceed 8%.

• Applicants are strongly encouraged to have someone other than the writer apply the screening requirements and evaluation criteria to the application prior to its submittal. In this way, applicants will gain a sense of their application's quality and potential competitiveness.

• Unless exempted, applicants must contact their SPOCs and, if requested, submit the required materials to their SPOCs to obtain their comments for consideration by HDS as part of the application review and award process.

• Applicants proposing projects targeted on individuals with developmental disabilities must submit a copy of the application to the State Developmental Disabilities Council for the State in which the project will be conducted. A listing of Councils may be requested by calling (202) 755–4633.

• *The activities below generally will not meet the purposes of this announcement when the activity is not in response to the outcomes described under Part II of the announcement:*

Projects whose main activity is a conference or meeting;

Projects whose major product is a manual;

Proposals which request expansion or continuation of existing services or programs; or,

Proposals which would establish clearinghouses.

BILLING CODE 4130-01-M

PRIORITY AREA: ———

OMB Approval No. 0348-0006

FEDERAL ASSISTANCE

1. TYPE OF SUBMISSION (Mark appropriate box)
- ☐ NOTICE OF INTENT (OPTIONAL)
- ☐ PREAPPLICATION
- ☐ APPLICATION

2. APPLICANT'S APPLICATION IDENTIFIER
- a. NUMBER: N/A
- b. DATE (Year month day): 19 N/A

3. STATE APPLICATION IDENTIFIER (NOTE TO BE ASSIGNED BY STATE)
- a. NUMBER: N/A
- b. DATE ASSIGNED (Year month day): N/A 19

Leave Blank

SECTION I—APPLICANT/RECIPIENT DATA

4. LEGAL APPLICANT/RECIPIENT
- a. Applicant Name .
- b. Organization Unit .
- c. Street/P.O. Box .
- d. City . e. County
- f. State . g. ZIP Code.
- h. Contact Person (Name & Telephone No.) .

5. EMPLOYER IDENTIFICATION NUMBER (EIN)

6. PROGRAM (From CFDA)
- a. NUMBER: N/A MULTIPLE ☐
- b. TITLE: N/A

7. TITLE OF APPLICANT'S PROJECT (Use section IV of this form to provide a summary description of the project.)

8. TYPE OF APPLICANT/RECIPIENT
A—State; B—Interstate; C—Substate Organization; D—County; E—City; F—School District; G—Special Purpose District; H—Community Action Agency; I—Higher Educational Institution; J—Indian Tribe; K—Other (Specify):
Enter appropriate letter ☐

9. AREA OF PROJECT IMPACT (Names of cities, counties, states, etc.): N/A

10. ESTIMATED NUMBER OF PERSONS BENEFITING

11. TYPE OF ASSISTANCE: N/A
A—Basic Grant; B—Supplemental Grant; C—Loan; D—Insurance; E—Other
Enter appropriate letter(s) ☐☐

12. PROPOSED FUNDING

a. FEDERAL	$	.00
b. APPLICANT		.00
c. STATE		.00
d. LOCAL		.00
e. OTHER		.00
f. Total	$	.00

13. CONGRESSIONAL DISTRICTS OF:
- a. APPLICANT
- b. PROJECT

15. PROJECT START DATE (Year month day): 19

16. PROJECT DURATION (Months)

18. DATE DUE TO FEDERAL AGENCY (Year month day): ► N/A 19

14. TYPE OF APPLICATION: N/A
A—New; B—Renewal; C—Revision; D—Continuation; E—Augmentation
Enter appropriate letter ☐

17. TYPE OF CHANGE (For 14c or 14e)
A—Increase Dollars; B—Decrease Dollars; C—Increase Duration; D—Decrease Duration; E—Cancellation; F—Other (Specify): N/A
Enter appropriate letter(s) ☐☐☐

19. FEDERAL AGENCY TO RECEIVE REQUEST: N/A
- a. ORGANIZATIONAL UNIT (IF APPROPRIATE): N/A
- b. ADMINISTRATIVE CONTACT (IF KNOWN): N/A
- c. ADDRESS: N/A

20. EXISTING FEDERAL GRANT IDENTIFICATION NUMBER: N/A

21. REMARKS ADDED: N/A ☐ Yes ☐ No

SECTION II—CERTIFICATION

22. THE APPLICANT CERTIFIES THAT ► To the best of my knowledge and belief, data in this preapplication/application are true and correct, the document has been duly authorized by the governing body of the applicant and the applicant will comply with the attached assurances if the assistance is approved.
- a. YES, THIS NOTICE OF INTENT/PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON: DATE _____
- b. NO, PROGRAM IS NOT COVERED BY E.O. 12372 ☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW ☐

23. CERTIFYING REPRESENTATIVE
- a. TYPED NAME AND TITLE
- b. SIGNATURE

SECTION III—FEDERAL AGENCY ACTION

24. APPLICATION RECEIVED (Year month day): 19

25. FEDERAL APPLICATION IDENTIFICATION NUMBER

26. FEDERAL GRANT IDENTIFICATION

27. ACTION TAKEN
- ☐ a. AWARDED
- ☐ b. REJECTED
- ☐ c. RETURNED FOR AMENDMENT
- ☐ d. RETURNED FOR E.O. 12372 SUBMISSION BY APPLICANT TO STATE
- ☐ e. DEFERRED
- ☐ f. WITHDRAWN

28. FUNDING

a. FEDERAL	$	.00
b. APPLICANT		.00
c. STATE		.00
d. LOCAL		.00
e. OTHER		.00
f. TOTAL	$	.00

29. ACTION DATE ► (Year month day): 19

30. STARTING DATE (Year month date): 19

31. CONTACT FOR ADDITIONAL INFORMATION (Name and telephone number)

32. ENDING DATE (Year month date): 19

33. REMARKS ADDED ☐ Yes ☐ No

NSN 7540-01-008-8162
PREVIOUS EDITION IS NOT USABLE

424-103

STANDARD FORM 424 PAGE 1 (Rev. 4-84)
Prescribed by OMB Circular A-102

OMB NO 0348-0006

PART II
PROJECT APPROVAL INFORMATION

Item 1
Does this assistance request require State, local regional, or other priority rating?
_____ Yes _____ No
Name of Governing Body _____
Priority Rating _____

Item 2
Does this assistance request require State, or local advisory, educational or health clearances?
_____ Yes _____ No (Attach Documentation)
Name of Agency or Board _____

Item 3
Does this assistance request require State, local regional or other planning approval?
_____ Yes _____ No
Name of Approving Agency _____
Date _____

Item 4
Is the proposed project covered by an approved comprehensive plan?
_____ Yes _____ No
Check one State ☐
Local ☐
Regional ☐
Location of Plan _____

Item 5
Will the assistance requested serve a Federal installation?
_____ Yes _____ No
Name of Federal Installation _____
Federal Population benefiting from Project _____

Item 6
Will the assistance requested be on Federal land or installation?
_____ Yes _____ No
Name of Federal Installation _____
Location of Federal Land _____
Percent of Project _____

Item 7
Will the assistance requested have an impact or effect on the environment
_____ Yes _____ No
See instructions for additional information to be provided

Item 8
Will the assistance requested cause the displacement of individuals, families, businesses, or farms?
_____ Yes _____ No
Number of
Individuals _____
Families _____
Businesses _____
Farms _____

Item 9
Is there other related assistance on this project previous, pending, or anticipated
_____ Yes _____ No
See instructions for additional information to be provided.

OMB NO 0348-0008

PART III - BUDGET INFORMATION

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	- Grant Program, Function or Activity				(Federal & Non-Federal) Total (5)
	(1)	(2)	(3)	(4)	
a. Personnel	$ N/A	$ N/A	$ N/A	$ N/A	$
b. Fringe Benefits	N/A	N/A	N/A	N/A	
c. Travel	N/A	N/A	N/A	N/A	
d. Equipment	N/A	N/A	N/A	N/A	
e. Supplies	N/A	N/A	N/A	N/A	
f. Contractual	N/A	N/A	N/A	N/A	
g. Construction	N/A	N/A	N/A	N/A	
h. Other	N/A	N/A	N/A	N/A	
i. Total Direct Charges	N/A	N/A	N/A	N/A	
j. Indirect Charges	N/A	N/A	N/A	N/A	
k. TOTALS	$ N/A	$ N/A	$ N/A	$ N/A	$
7. Program Income	$ N/A	$ N/A	$ N/A	$ N/A	$

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS)			
	(b) FIRST	(c) SECOND	(d) THIRD	(e) FOURTH
16. N/A	$ N/A	$ N/A	$ N/A	$ N/A
17. N/A	N/A	N/A	N/A	N/A
18. N/A	N/A	N/A	N/A	N/A
19. N/A	N/A	N/A	N/A	N/A
20. TOTALS (Federal request only)	$	$	$ N/A	$ N/A

PART V

ASSURANCES

The Applicant hereby assures and certifies that it will comply with the regulations, policies, guidelines and requirements, including 45 CFR Part 74 and OMB Circulars No. A-102, A-110 and applicable cost principles, (Circulars: A-21, "Educational Institutions"; A-87, "Cost Principles for State and Local Governments"; and A-122, "Nonprofit Organizations"), as they relate to the application, acceptance and use of Federal funds for this Federally assisted project. Also the applicant assures and certifies with respect to the grant that:

1. It possesses legal authority to apply for the grant; that a resolution, motion or similar action has been duly adopted or passed as an official act of the applicant's governing body, authorizing the filing of the application, including all understandings and assurances contained therein, and directing and authorizing the person identified as the official representative of the applicant to act in connection with the application and to provide such additional information as may be required.

2. It will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and in accordance with Title VI of that Act, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the applicant receives Federal financial assistance and will immediately take any measures necessary to effectuate this agreement.

3. It will comply with Title VI of the Civil Rights Act of 1964 (42 USC 2000d) prohibiting employment discrimination where (1) the primary purpose of a grant is to provide employment or (2) discriminatory employment practices will result in unequal treatment of persons who are or should be benefiting from the grant-aided activity.

4. It will comply with requirements of the provisions of the Uniform Relocation Assistance and Real Property Acquisition Act of 1970 (P.L. 91-646) which provides for fair and equitable treatment of persons displaced as a result of Federal and federally-assisted programs.

5. It will comply with the provisions of the Hatch Act which limit the political activity of State and local government employees.

6. It will comply with the minimum wage and maximum hours provisions of the Federal Fair Labor Standards Act (29 U.S.C. 201) as they apply to employees of institutions of higher education, hospitals, other nonprofit organizations, and to employees of State and local governments who are not employed in integral operations in areas of traditional governmental functions.

   Head Start, Certification of Minimum Wage: It certifies that it has reviewed the salary structures and wages for all positions and certifies that persons employed in carrying out this program shall not receive compensation at a rate which is (a) in excess of the average rate of compensation paid in the area to persons providing substantially comparable services; or (b) less than the minimum wage rate prescribed in section 6(a) of the Fair Labor Standards Act of 1938. Documentation of the methods by which it established wage scales is available in their files for review by audit and HDS personnel.

7. It will establish safeguards to prohibit employees from using their positions for a purpose that is or gives the appearance of being motivated by a desire for private gain for themselves or others, particularly those with whom they have family, business, or other ties.

8. It will give the sponsoring agency or the Comptroller General through any authorized representative the access to and the right to examine all records, books, papers, or documents related to the grant, including the records of contractors and subcontractors performing under the grant.

9. It will comply with all requirements imposed by the Federal sponsoring agency concerning special requirements of law, program requirements, and other administrative requirements.

10. It will insure that the facilities under its ownership, lease or supervision which shall be utilized in the accomplishment of the project are not listed on the Environmental Protection Agency's (EPA) list of Violating Facilities and that it will notify the Federal grantor agency of the receipt of any communication from the Director of the EPA Office of Federal Activities indicating that a facility to be used in the project is under consideration for listing by the EPA.

The phrase "Federal financial assistance" includes any form of loan, grant, guaranty, insurance payment, rebate, subsidy, disaster assistance loan or grant, or any other form of direct or indirect Federal assistance.

11. It will comply with the flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973, Public Law 93-234, 87 Stat. 975, approved December 31, 1976. Section 102(a) requires, on and after March 2, 1975, the purchase of flood insurance in communities where such insurance is available as a condition for the receipt of any Federal financial assistance for construction or acquisition purposes for use in any area that has been identified by the Secretary of the Department of Housing and Urban Development as an area having special flood hazards.

12. It will assist the Federal grantor agency in its compliance with Section 106 of the National Historic Preservation Act of 1966 as amended (16 U.S.C. 470), Executive Order 11593, and the Archeological and Historic Preservation Act of 1966 (16 U.S.C. 469a-1 et seq.) by (a) consulting with the State Historic Preservation Officer on the conduct of investigations, as necessary, to identify properties listed in or eligible for inclusion in the National Register of Historic Places that are subject to adverse effects (see 36 CFR Part 800.8) by the grantee's activity and notifying the Federal grantor agency of the existence of any such properties, and by (b) complying with all requirements established by the Federal grantor agency to avoid or mitigate adverse effects upon such properties.

13. Applicants for the Administration for Native Americans Programs, hereby certify in accordance with 45 CFR 1336.53, that the financial assistance provided by the Office of Human Development Services for the specified activities to be performed under this program, will be in addition to, and not in substitution for, comparable activities provided without Federal assistance.

14. It will comply with the Age Discrimination Act of 1975 enacted as an amendment to the Older Americans Act (Pub. L. 94-135), which provides that: No person in the United States shall, on the basis of age be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity for which the applicant receives Federal financial assistance.

15. It will comply with Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by the applicable HHS regulation (45 C.F.R. Part 84), and all guidelines and interpretations issued pursuant thereto, which prohibits discrimination on the basis of handicap in programs and activities receiving Federal financial assistance.

16. It will comply with Title IX of the Education Amendments of 1972 (20 U.S.C. 1681, et seq.) which prohibits discrimination on the basis of sex in education programs and activities receiving Federal financial assistance (whether or not the programs or activities are offered or sponsored by an educational institution).

17. It will comply with Pub. L. 93-348 as implemented by Part 46 of Title 45 (45 CFR 46, 42 U.S.C. 2891) regarding the protection of human subjects involved in research, development, and related activities supported by the grant.

18. It will comply with the equal opportunity clause prescribed by Executive Order 11246, as amended, and will require that its subrecipients include the clause in all construction contracts and subcontracts which have or are expected to have an aggregate value within a 12-month period exceeding $10,000, in accordance with Department of Labor regulations at 41 CFR Part 60.

19. It will include, and will require that its subrecipients include, the provision set forth in 29 CFR 5.5(c) pertaining to overtime and unpaid wages in any nonexempt nonconstruction contract which involves the employment of mechanics and laborers (including watchmen, guards, apprentices, and trainees) if the contract exceeds $2,500.

ASSURANCE OF COMPLIANCE WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES REGULATION UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

_____ (hereinafter called the "Applicant") HEREBY
Name of Applicant (type or print)

AGREES THAT it will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 80) issued pursuant to that title, to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department; and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. In all other cases, this assurance shall obligate the Applicant for the period during which the Federal financial assistance is extended to it by the Department.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts or other Federal financial assistance extended after the date hereof to the Applicant by the Department, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The Applicant recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this assurance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Applicant, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Applicant.

Date _____ By _____
Signature and Title of Authorized Official

_____
Area Code — Telephone Number

_____
Applicant (type or print)

_____
Street Address

_____
City State Zip

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSURANCE OF COMPLIANCE WITH SECTION 504 OF THE REHABILITATION ACT OF 1973, AS AMENDED

The undersigned (hereinafter called the "recipient") HEREBY AGREES THAT it will comply with section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by the applicable HHS regulation (45 C.F.R. Part 84), and all guidelines and interpretations issued pursuant thereto.

Pursuant to § 84.5(a) of the regulation [45 C.F.R. 84.5(a)], the recipient gives this Assurance in consideration of and for the purpose of obtaining any and all federal grants, loans, contracts (except procurement contracts and contracts of insurance or guaranty), property, discounts, or other federal financial assistance extended by the Department of Health and Human Services after the date of this Assurance, including payments or other assistance made after such date on applications for federal financial assistance that were approved before such date. The recipient recognizes and agrees that such federal financial assistance will be extended in reliance on the representations and agreements made in this Assurance and that the United States will have the right to enforce this Assurance through lawful means. This Assurance is binding on the recipient, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the recipient.

This Assurance obligates the recipient for the period during which federal financial assistance is extended to it by the Department of Health and Human Services or, where the assistance is in the form of real or personal property, for the period provided for in § 84.5(b) of the regulation [45 C.F.R. 84.5(b)].

The recipient: [Check (a) or (b)]

a. ( ) employs fewer than fifteen persons;

b. ( ) employs fifteen or more persons and, pursuant to § 84.7(a) of the regulation [45 C.F.R. 84.7(a)], has designated the following person(s) to coordinate its efforts to comply with the HHS regulation:

_____

Name of Designee(s) — Type or Print

Name of Recipient — Type or Print	Street Address
(IRS) Employer Identification Number	City
Area Code — Telephone Number	State Zip

I certify that the above information is complete and correct to the best of my knowledge.

Date	Signature and Title of Authorized Official

If there has been a change in name or ownership within the last year, please PRINT the former name below:

HHS-641 (7/84) REV.)
GPO 908-714

BILLING CODE 4130-01-C

HDS GRANTS MANAGEMENT

Executive Order 12372—State Single Points of Contact

Alabama

Mrs. Donna J. Snowden, SPOC, Alabama State Clearinghouse, Alabama Department of Economic and Community Affairs, 3465 Norman Bridge Road, Post Office Box 2939, Montgomery, Alabama 36105–0939, Tel. (205) 284–8905

Alaska

None.

Arizona

Department of Commerce, State of Arizona.

Note.—Correspondence & questions concerning this State's E.O. 12372 process should be directed to:
Janice Dunn, Attn: Arizona State Clearinghouse, 1700 West Washington, Fourth Floor, Phoenix, Arizona 85007, Tel. (602) 255–5004

Arkansas

State Clearinghouse, Office of Intergovernmental Services, Department of Finance and Administration, P.O. Box 3278, Little Rock, Arkansas 72203, Tel. (501) 371–1074

California

Office of Planning and Research, 1400 Tenth Street, Sacramento, California 95814, Tel. (916) 323–7480

Colorado

State Clearinghouse, Division of Local Government, 1313 Sherman Street, Rm. 520, Denver, Colorado 80203, Tel. (303) 866–2156

Connecticut

Gary E. King, Under Secretary, Comprehensive Planning Division, Office of Policy and Management, Hartford, Connecticut 06106–4459

Note.—Correspondence & questions concerning this State's E.O. 12372 process should be directed to:
Intergovernmental Review Coordinator, Comprehensive Planning Division, Office of Policy and Management, 80 Washington Street, Hartford, Connecticut 06106–4459, Tel. (203) 566–3410

Delaware

Executive Department, Thomas Collins Building, Dover, Delaware 19903, Attn: Francine Booth, Tel. (302) 736–4204

Florida

Ron Fahs, Executive Office of the Governor, Office of Planning and Budgeting, The Capitol, Tallahassee, Florida 32301, Tel. (904) 488–8114

Georgia

Charles H. Badger, Administrator, Georgia State Clearinghouse, 270 Washington Street, SW., Atlanta, Georgia 30334, Tel. (404) 656–3855

Hawaii

Kent M. Keith, Director, Department of Planning and Economic Development, P.O. Box 2359, Honolulu, Hawaii 96804
For Information Contact: Hawaii State Clearinghouse, Tel. (808) 548–3016 or 548–3085

Idaho

None

Illinois

Tom Berkshire, Office of the Governor, State of Illinois, Springfield, Illinois 62706, Tel. (217) 782–8639

Indiana

Mr. Alexander J. Ingram, Deputy Director, State Budget Agency, 212 State House, Indianapolis, Indiana 46204, Tel. (317) 232–5604

Iowa

Office for Planning and Programming, Capitol Annex, 523 East 12th Street, Des Moines, Iowa 50319, Tel. (515) 281–3864

Kansas

Ms. Judy Krueger, Intergovernmental Liaison, 122 A South, State Office Building, Topeka, Kansas 66612, Tel. (913) 296–3919

Kentucky

Kentucky State Clearinghouse, 2nd Floor, Capital Plaza Tower, Frankfort, Kentucky 40601, Tel. (502) 564–2382

Louisiana

Mr. Ferguson Brew, Assistant Secretary and SPOC, Dept. of Urban & Community Affairs, Office of State Clearinghouse, P.O. Box 94455, Capitol Station, Baton Rouge, Louisiana 70804, Tel. (504) 925–3725

Maine

State Planning Office, Attn: Intergovernmental Review Process/ Hal Kimbal, State House Station #38, Augusta, Maine 04333, Tel. (207) 289–3154

Maryland

Guy W. Hager, Director, Maryland State Clearinghouse for Intergovernmental Assistance, Department of State Planning, 301 West Preston Street, Baltimore, Maryland 21201–2365, Tel. (301) 225–4490

Massachusetts

Executive Office of Communities and Development, Attn: Beverly Boyle, 100 Cambridge Street, Rm. 904, Boston, Massachusetts 02202, Tel. (617) 727–3253

Michigan

Michelyn Pasteur, Director, Local Development Services, Department of Commerce, P.O. Box 30225, Lansing, Michigan 48909, Tel. (517) 373–3530

Minnesota

Maurice D. Chandler, Intergovernmental Review, Minnesota State Planning Agency, Room 101, Capitol Square Building, St. Paul, Minnesota 55101, Tel. (612) 296–2571

Mississippi

Office of Federal State Programs, Department of Planning and Policy, 2000 Walter Sillers Bldg., 500 High Street, Jackson, Mississippi 39202
For Information Contact: Mr. Marlan Baucum, Department of Planning and Policy, Tel. (601) 359–3150

Missouri

Lois Pohl, Coordinator, Missouri Federal Assistance Clearinghouse, Office of Administration, Division of General Services, P.O. Box 809, Room 760 Truman Building, Jefferson City, Missouri 65102, Tel. (314) 751–4834

Montana

Sue Heath, Intergovernmental Review Clearinghouse, c/o Office of the Lieutenant Governor, Capitol Station, Helena, Montana 59620, Tel. (406) 444–5522

Nebraska

None

Nevada

Ms. Jean Ford, Director, Nevada Office of Community Services, Capitol Complex, Carson City, Nevada 89710, Tel. (702) 885–4420

Note.—Correspondence & questions concerning this State's E.0. 12372 process should be directed to:
John Walker, Clearinghouse Coordinator, Tel. (702) 885–4420

New Hampshire

David G. Scott, Acting Director, New Hampshire Office of State Planning, 2½ Beacon Street, Concord, New Hampshire 03301, Tel. (603) 271–2155

New Jersey

Mr. Barry Skokowski, Director, Division of Local Government Services, Department of Community Affairs, CN

803, 363 West State Street, Trenton, New Jersey 08625–0803, Tel. (609) 292–6613

Note.—Correspondence & questions concerning this State's E.O. 12372 process should be directed to:

Nelson S. Silver, State Review Process, Division of Local Government Services—CN 803, Trenton, New Jersey 08625–0803, Tel. (609) 292–9025

New Mexico

Peter C. Pence, Director, Department of Finance and Administration, Management and Contracts Review Div., Clearinghouse Bureau, Room 424, State Capitol, Santa Fe, New Mexico 87503, Tel. (505) 827–3885

New York

Director of the Budget, New York State

Note.—Correspondence & questions concerning this State's E.O. 12372 process should be directed to:

New York State Clearinghouse, Division of the Budget, State Capitol, Albany, New York 12224, Tel. (518) 474–1605

North Carolina

Mrs. Chrys Baggett, Director, State Clearinghouse, Department of Administration, 116 West Jones Street, Raleigh, North Carolina 27611, Tel. (919) 733–4131

North Dakota

Office of Intergovernmental Assistance, Office of Management and Budget, 14th Floor, State Capitol, Bismarck, North Dakota 58505, Tel. (701) 224–2094

Ohio

State Clearinghouse, Office of Budget and Management, 30 East Broad Street, Columbus, Ohio 43215

For Information Contact: Mr. Leonard E. Roberts, Deputy Director, Tel. (614) 466–0699

Oklahoma

Don Strain, Office of Federal Assistance Management, 4545 North Lincoln Blvd., Oklahoma City, Oklahoma 73105, Tel. (405) 528–8200

Oregon

Intergovernmental Relations Division, State Clearinghouse, Attn: Delores Streeter, Executive Building, 155 Cottage Street, NE., Salem, Oregon 97310, Tel. (503) 373–1998

Pennsylvania

Barbara J. Gontz, Project Coordinator, Pennsylvania Intergovernmental Council, P.O. Box 11880, Harrisburg, Pennsylvania 17108, Tel. (717) 783–3700

Rhode Island

Daniel W. Varin, Chief, Rhode Island Statewide Planning Program, 265 Melrose Street, Providence, Rhode Island 02907, Tel. (401) 277–2656

Note.—Questions & correspondence concerning this State's review process should be directed to:

Mr. Michael T. Marfeo, Review Coordinator

South Carolina

Danny L. Cromer, Grant Services, Office of the Governor, 1205 Pendleton Street, Rm. 477, Columbia, South Carolina 29201, Tel. (803) 758–2417

South Dakota

Connie Tveidt, State Clearinghouse Coordinator, State Government Operations, Second Floor, Capitol Building, Pierre, South Dakota 57501, Tel. (605) 773–3661

Tennessee

Tennessee State Planning Office, 1800 James K. Polk Building, 505 Deaderick Street, Nashville, Tennessee 37219, Tel. (615) 741–1676

Texas

Bob McPherson, State Planning Director, Office of the Governor, P.O. Box 13561, Capitol Station, Austin, Texas 78711

Note.—Questions concerning this State's review process should be directed to:

Intergovernmental Relations Division, Tel. (512) 463–1778

Utah

Dale Hatch, Director, Office of Planning and Budget, State of Utah, 116 State Capitol Building, Salt Lake City, Utah 84114, Tel. (801) 533–5245

Vermont

State Planning Office, Attn: Bernie Johnson, Pavilion Office Building, 109 State Street, Montpelier, Vermont 05602, Tel. (802) 828–3326

Virginia

Shawn McNamara, Department of Housing and Community Development, 205 North 4th Street, Richmond, Virginia 23219, Tel. (804) 786–4474

Washington

Washington Department of Community Development, ATTN: Washington Intergovernmental Review process, Dori Goodrich, Coordinator, Ninth and Columbia Building, Olympia, Washington 98504–4151, Tel. (206) 586–1240

West Virginia

Mr. Fred Cutlip, Director, Community Development Division, Governor's Office of Community and Industrial Development, Building #6, Rm. 553, Charleston, West Virginia 25305, Tel (304) 348–4010

Wisconsin

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Virgin Islands

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Northern Mariana Islands

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American Samoa

None

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List of Key Words

Abused elderly
Accreditation
Adoption
Advocacy and guardianship
Adult day care (use home care with aging and elderly)
Adults
Aging and elderly
Aging-out

Agriculture
Allied professional education
Alternative financing
Asians
Barrier-free design
Blacks
Board and care
Budgeting and finance
Business development training
Cable television
Career and vocational education
Case Management
Child abuse and neglect
Child care
Child care centers
Children
Clearinghouse
Client outcome measures
Colleges and Universities
Community Care
Community-based organizations
Competitive employment
Comprehensive care
Computer networks
Computers
Conferences
Congregate housing
Consumer education
Continuing education
Contracting
Cooperatives
Coordination
Corrections
Counseling
Courts
Crisis intervention
Cross-cultural
Cross-cutting
Cultural activities
Curriculum development
Data collection
Day care
Day care centers
Deinstitutionalization
Design
Developmentally disabled
Dissemination
Dropouts
Economic development
Education and training
Effectiveness measures
Efficiency
Emergency services
Emergency shelters
Employer-supported human services
Employment
Entrepreneurship
Environment
Environmental design
Evaluation
Exploited youth
Families
Family counseling
Family day care
Family support
Films
Finance
Fire safety
Fiscal management
Food and nutrition
Food banks
Forecasting
Foster care
Foster grandparents
Foundations
Frail elderly
Friendly visitors
Gerontology training
Group homes
Guardianship
Handbooks
Historically Black Colleges and Universities (use HBCU)
Head Start
Health
Hispanics
Home care
Home equity conversions
Homeless
Hospitals
Hospices and nursing homes
Housing
Human services
Immigrants and refugees
Income generation
Independent living
Indians
Infants and toddlers
Informal caregivers
Information centers
Information and referral
In-home care
Institutionalization
Information transfer
Interagency cooperation
Interdisciplinary
Intergenerational
Interstate agreements
Investigations
Isolated elderly
Job bank
Job clubs
Job placement
Judicial system
Juvenile justice
Latchkey and school-age children
Law enforcement
Legal
Legal counseling
Legislation and model codes
Linkages
Living skills
Low-cost alternatives
Low-income
Mainstreaming
Management
Management Information Systems
Management training
Manuals
Marketing
Materials
Meals
Media
Medical
Mental health
Mentally disabled
Mentors
Microcomputers
Minorities
Native Alaskans
Native Americans
Needs assessment
Newsletters
Newspapers
Nursing homes
Nutrition counseling
On-the-job training
Outreach
Parent education
Peer counseling
Performance-based contracting
Permanancy planning
Physically disabled
Planning
Preschools
Prevention
Preventive care
Primary schools
Private sector
Prostitution
Public education
Public-private cooperation
Radio
Rate-setting
Readiness skills
Recreation
Recruitment
Recycling
Referral
Refugees
Research
Residential care
Resource allocation
Respite care
Retirement
Runaways
Rural
Samoans
School-age children
Secondary schools
Self-care
Self-help
Seminars
Sheltered workshops
Single parents
Small business
Social services
Software
Special education
Special needs adoption
Speech impairment
Standards
Support groups
Target populations
Television
Taxes
Technical assistance
Technology transfer
Teenage parents
Telecommunications
Therapeutic day care
Toddlers
Training
Training of trainers
Transitioning
Transportation
Unemployed
Urban
User fees
Video
Visual Impairment
Vocational training
Volunteers
Vouchers
Women
Workplace
Youth

Dated: September 24, 1986.

Jean K. Elder,

Acting Assistant Secretary for Human Development Services.

Dodie Livingston,

Commissioner, Administration for Children, Youth and Families.

Casimer R. Wichlacz,

Acting Commissioner, Administration on Developmental Disabilities.

Carol Fraser Fisk,

Commissioner, Administration on Aging.

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Federal Register

Tuesday
September 30, 1986

Part IV

Department of Health and Human Services

Health Care Financing Administration

Office of the Secretary

Office of Inspector General

42 CFR Chapter V, et al.

45 CFR Part 101

Medicare and Medicaid Programs, Office of Inspector General Regulations; Establishment of CFR Chapter; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Office of Inspector General

42 CFR Ch. V

45 CFR Part 101

Medicare and Medicaid Programs; Establishment of Chapter V for OIG Regulations

AGENCY: Office of the Secretary, Office of Inspector General, HHS.

ACTION: Final rule.

SUMMARY: This rule establishes all Office of Inspector General (OIG) authorities, currently contained in 45 CFR Part 101 and various portions of 42 CFR Parts 412, 420, 455, 474 and 489, in a new 42 CFR Chapter V, and reflects the 1983 transfer of the fraud and abuse responsibilities under Medicare and Medicaid from the Health Care Financing Administration (HCFA) to the OIG. While a number of conforming changes to the regulations setting forth the OIG responsibilities have previously been made (50 FR 37370, September 13, 1985) the purpose of this rule is to specifically place these authorities delegated to the OIG into a separate chapter of the Medicare/Medicaid volume within the Code of Federal Regulations. Several conforming and technical changes are also being made at this time to reflect the establishment of Chapter V.

EFFECTIVE DATE: September 30, 1986.

FOR FURTHER INFORMATION CONTACT: James Patton, (301) 594–1816.

SUPPLEMENTARY INFORMATION:

I. Transfer of Fraud and Abuse Authorities

On April 18, 1983, the Secretary of Health and Human Services transferred the authorities for controlling fraud and abuse in the Department's health care financing programs from the Health Care Financing Administration (HCFA) to the Office of Inspector General (OIG) (48 FR 21662, May 13, 1983). (Also see 48 FR 45306, October 4, 1983, and 49 FR 29849, July 24, 1984.) Specifically, this delegation of authority provides that the OIG will make the necessary determinations and effectuate appropriate sanctions under sections 1128, 1156(b), 1160(b) (as set forth prior to Pub. L. 97–248), 1862(d) (1) and (2), and 1866(b)(2) (D), (E) and (F) of the Social Security Act, and take action under section 1866(c)(1) with respect to determinations taken under section 1866(b)(2) (D), (E) or (F) of the Act. To reflect this transfer of fraud and abuse authority to the OIG, final regulations—the Medicare and Medicaid Fraud and Abuse Technical Amendments—were published on September 13, 1985 (50 FR 37370) making various conforming changes in the HHS regulations at 42 CFR Parts 420, 455 and 489. To further reflect this distinction of responsibility and authority, we are now placing the appropriate portions of those regulations contained in 42 CFR Chapter IV, and 45 CFR Part 101 (Civil Money Penalties and Assessments), into a newly established Chapter V—"Office of Inspector General—Health Care, Department of Health and Human Services." A derivation table, following this preamble, specifically identifies those sections of 42 CFR Chapter IV and 45 CFR Subtitle A from which the new Chapter V derives its content.

II. Fraud and Abuse Authorities Not Delegated to the OIG

In addition to the authorities cited above that have been explicitly delegated to the OIG, there are a number of other statutory authorities relating to program fraud and abuse under Medicaid that have been retained by HCFA. For example, HCFA continues to retain specific responsibility for enforcing State plan requirements, even though some of these requirements pertain to State obligations in enforcing OIG sanction authorities. The HCFA-delegated authorities include sections 1126, 1902(a)(4)(A), 1902(a)(30), 1902(a)(39), 1903(i)(2) and 1903(n). While HCFA continues to retain the delegated authorities for enforcing these provisions, we are including specific regulations based on these authorities in Part 1002, Subparts A and B of Chapter V for the convenience of developing a complete and comprehensive regulatory package that sets forth the Department's fraud and abuse related provisions in one location.

III. Functions Delegated to the OIG

The following is a brief summary of those functions presently assumed by the OIG and a brief description of the regulations that are being redesignated and modified under this recodification.

1. Program Integrity Regulations

The Office of Inspector General has been delegated the authority under section 1128 of the Social Security Act to suspend from participation in the Medicare program, and to require the States to suspend from the Medicaid program, physicians and other individuals who have been convicted of fraudulent activities against the Medicare or Medicaid programs. The OIG has also been delegated the authority provided by section 1862(d)(1)(A), (B) and (C) of the Act to exclude from coverage items and services furnished by practitioners, providers or other suppliers of health care services who have made false statements in applying for Medicare payment or have engaged in certain forms of program abuse, and to terminate provider agreements for the same reasons under section 1866(b)(2) (D), (E) and (F) of the Act. Where Medicare reimbursement is precluded as a result of suspension, exclusion or termination, Federal financial participation is not available for Medicaid.

Additionally, the OIG has also been delegated specific authority under section 1866(c)(1) of the Act. Under this authority, where an agreement filed by a provider has been terminated by the OIG, such provider may not file another agreement unless the OIG finds that the reason for the termination has been removed and that there is reasonable assurance that it will not recur.

While the OIG has a broad mandate and full responsibility for case development and the imposition of sanctions against individual health care providers as a result of criminal and civil litigation or program abuse, the OIG technical amendment regulations, published September 13, 1985, reflected a "shared" administrative responsibility between the OIG and HCFA in notifying all responsible parties of any sanctions action, and will be contained in both the HCFA chapter and in the new OIG chapter. Parties to be notified include, among others, the affected party, the general public, licensing boards and professional societies, and the State Medicaid Fraud Control Unit, where appropriate. Notification to program beneficiaries as a group, however, will remain a HCFA responsibility.

Specific changes. Major portions of current regulations contained in Subpart B of Part 420, Exclusion or Suspension of Practitioners, Providers, Suppliers of Services, and Other Individuals are being redesignated and revised to read as a new 42 CFR Chapter V, Part 1001. Portions of 42 CFR Part 489, Subpart E (Withholding of Payment, Termination of Agreement and Reinstatement after Termination) specific to OIG's delegated authority are also being duplicated and included in the same Chapter V, Part 1001 to reflect the responsibility of both HCFA and OIG to terminate provider agreements under the authorities respectively delegated to each. Those portions of the termination provisions that are HCFA-specific will continue to

be contained in 42 CFR 489.53. Further, those subparts of the prospective payment regulations at 42 CFR 412.48, that relate to OIG responsibility for making determinations with respect to sanctions under sections 1862(d) and 1866(b) of the Act, are also being redesignated and revised for inclusion into Part 1001 of the New Chapter V.

In addition, the current regulations contained in Subparts C (Exclusion of Providers and Suspension of Practitioners and Other Individuals) and D (State Medicaid Fraud Control Units) of Part 455, dealing with certification and recertification, are also being redesignated into the new 42 CFR Chapter V, Part 1002.

2. Civil Monetary Penalty and Peer Review Organization Sanction Regulations

The current regulations contained in 45 CFR Part 101 specify procedures for implementing the authority provided to the Department by sections 1128A and 1128(c) of the Social Security Act, as amended by section 2105 of the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97–35) and section 137(b)(26) of the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97–248), to administratively impose civil money penalties and assessments for the filing of false or certain other improper claims in the Medicare, Medicaid, or Maternal and Child Health Services Block Grant programs. The regulations also permit the Department to suspend from participation in the Medicare and Medicaid programs an individual upon whom the Department has imposed a civil money penalty or assessment. Under these regulations, violators may be fined up to $2,000 as a penalty for each false or improper item or service, and an additional assessment of up to twice the amounts falsely claimed for each item or service. The rule also provides to those persons against whom civil money penalties and assessments have been proposed an opportunity for a hearing on the record in accordance with the Administrative Procedure Act, for an appeal to the Secretary, and for judicial review of the Secretary's final determination.

In addition, current regulations at 42 CFR Part 474, implementing the Peer Review Improvement Act of 1982, specifically establish sanctions that the OIG may impose on health care practitioners and other persons for violations of certain program obligations under section 1156 of the Act. Under these regulations, the OIG, based on a PRO recommendation, is authorized to exclude practitioners and other persons from the Medicare program or, in lieu of exclusion, require payment of a monetary penalty as a condition of continued eligibility to receive reimbursement under the program.

Specific changes. The current regulations contained in 45 CFR Part 101, Civil Money Penalties and Assessments, as well as appropriate portions of 42 CFR Part 474, Imposition of Sanctions on Health Care Practitioners and Providers of Health Care Services, are being redesignated and revised for inclusion into the new 42 CFR Chapter V, Parts 1003 and 1004, respectively.

IV. Regulatory Impact Statement

Since this rule makes no substantive changes in current regulations, there is no need for the analysis required by Executive Order 12291 for rules that have a significant impact on the economy.

In addition, because this rule does not require a general notice of proposed rulemaking under the Administrative Procedure Act (5 U.S.C. 553(b)), it is not subject to the requirements for regulatory flexibility analysis imposed under the Regulatory Flexibility Act of 1980 (5 U.S.C. 601–612).

Paperwork Reduction Act Statement

Under the Paperwork Reduction Act of 1980, the Department is required to obtain Office of Management and Budget (OMB) approval for all information collection requirements. As indicated above, these regulations are merely a recodification of existing regulations and therefore establish no new information collection requirements. The information collection requirements contained in §§ 1004.40, 1004.50, 1004.60 and 1004.70 are approved under OMB control number 0938–0444. Sections 1002.3, 1002.204, 1002.206, 1002.212 and 1002.234 contain information collection requirements which are not currently approved by OMB. The Department is seeking OMB approval of these requirements and will publish a notice in the **Federal Register** when OMB approval is obtained.

V. Waiver of Notice of Proposed Rulemaking

Because this rule makes no substantive changes in the regulations that it redesignates, we find that notice of proposed rulemaking is unnecessary.

VI. List of Subjects

42 CFR Part 1001

Cancer hospitals, Christian Science sanitoria, Discharges and transfers, Inpatient hospital services, Outlier cases, Prospective payment referral centers, Renal transplantation centers, Sole community hospitals, Abuse, Administrative practice and procedures, Contracts (Agreements), Conviction, Convicted, Courts, Exclusion, Fraud, Health care, Health facilities, Health Maintenance Organizations (HMO), Health professions, Health suppliers, Information (disclosure), Lawyers, Medicaid, Medicare, Penalties, Reporting and recordkeeping requirements, Supervision, Utilization and Quality Control Peer Review Organizations (PRO).

42 CFR Part 1002

Abuse, Administrative practice and procedure, Claim, Conviction, Convicted, Exclusion, Grant-in-Aid program—health, Health care, Health facilities, Health professions, Information (disclosure), Investigations, Medicaid, Medicaid Fraud Control Units, Medicaid personnel, Penalties, Reporting requirements, Suspension.

45 CFR Part 1003

Administrative practice and procedures, Archives and records, Grant programs—social programs, Maternal and child health, Medicaid, Medicare, Penalties.

42 CFR Part 1004

Health care, Health professions, Penalties, Utilization and Quality Control Peer Review Organizations (PRO), Reporting and recordkeeping requirements.

VII. Derivation Table

This table identifies the sections of 42 CFR Chapter IV and 45 CFR Subtitle A from which the new 42 CFR Chapter V derives its content. In the case of Title 45, all of the source sections were redesignated. In the case of 42 CFR Chapter IV, some of the source sections were redesignated, but others were retained in Chapter IV and duplicated in Chapter V.

New Section	Source Section
	42 CFR Chapter IV
1001.1	420.1
1001.2	420.2
1001.3	420.3
1001.100	420.100
1001.101	420.101
1001.102	420.102
1001.103	420.103
1001.105	420.105
1001.107	420.107
1001.109	420.109
1001.114	420.114
1001.115	420.115
1001.122	420.122
1001.123	420.123
1001.124	420.124
1001.125	420.125
1001.126	420.126
1001.128	420.128
1001.130	420.130
1001.132	420.132

New Section	Source Section
	42 CFR Chapter IV
1001.134	420.134
1001.136	420.136
1001.201	489.54
1001.211	489.55
1001.221	489.57
1001.301	412.48(c), (d), and (e)
1002.1	455.1
1002.2	455.2
1002.3	455.106
1002.200	455.200
1002.203	455.203
1002.204	455.204
1002.205	455.205
1002.206	455.206
1002.207	455.207
1002.208	455.208
1002.210	455.210
1002.211	455.211
1002.212	455.212
1002.213	455.213
1002.214	455.214
1002.230	455.230
1002.232	455.234
1002.234	455.234
1002.301-1002.321	455.300
	45 CFR Subtitle A
1003.100	101.100
1003.101	101.101
1003.102	101.102
1003.103	101.103
1003.104	101.104
1003.105	101.105
1003.106	101.106
1003.107	101.107
1003.108	101.108
1003.109	101.109
1003.110	101.110
1003.111	101.111
1003.112	101.112
1003.113	101.113
1003.114	101.114
1003.115	101.115
1003.116	101.116
1003.117	101.117
1003.118	101.118
1003.119	101.119
1003.120	101.120
1003.122	101.122
1003.123	101.123
1003.124	101.124
1003.125	101.125
1003.126	101.126
1003.127	101.127
1003.128	101.128
1003.129	101.129
1003.130	101.130
1003.131	101.131
1003.132	101.132
1003.133	101.133
	42 CFR Chapter IV
1004.1	474.0
1004.10	474.30
1004.20	474.32
1004.30	474.34
1004.40	474.36
1004.50	474.38
1004.60	474.39
1004.70	474.40
1004.80	474.41
1004.90	474.42
1004.100	474.52
1004.110	474.54
1004.120	474.56
1004.130	474.58

Titles 42 and 45 of the Code of Federal Regulations are amended as follows:

TITLE 42—[AMENDED]

I. In Title 42 of the Code of Federal Regulations, a new Chapter V—Office of Inspector General—Health Care—is established to read as follows:

CHAPTER V—OFFICE OF INSPECTOR GENERAL—HEALTH CARE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Subchapter A—General Provisions

Part

1000 Introduction; General definitions

Subchapter B—OIG Authorities

1001 Program Integrity—Medicare
1002 Program Integrity—Medicaid
1003 Civil Money Penalties and Assessments
1004 Imposition of Sanctions on Health Care Practitioners and Providers of Health Care Services by a Peer Review Organization
1005–1010 [Reserved]

Subchapter A—General Provisions

PART 1000—INTRODUCTION; GENERAL DEFINITIONS

Subpart A—[Reserved]

Subpart B—Definitions

Sec.

1000.10 General definitions.
1000.20 Definitions specific to Medicare.
1000.30 Definitions specific to Medicaid.

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart A—[Reserved]

Subpart B—Definitions

§ 1000.10 General definitions.

In this chapter, unless the context indicates otherwise—

"Act" means the Social Security Act, and titles referred to are titles of that Act.

"Administrator" means the Administrator, Health Care Financing Administration.

"CFR" stands for Code of Federal Regulations.

"Department" means the Department of Health and Human Services (HHS), formerly the Department of Health, Education, and Welfare.

"ESRD" stands for end-stage renal disease.

"FR" stands for *Federal Register*.

"HCFA" stands for Health Care Financing Administration.

"HHS" stands for the Department of Health and Human Services.

"HHA" stands for home health agency.

"HMO" stands for health maintenance organization.

"ICF" stands for intermediate care facility.

"Inspector General" means the Inspector General for Health and Human Services.

"Medicaid" means medical assistance provided under a State plan approved under Title XIX of the Act.

"Medicare" means the health insurance program for the aged and disabled under Title XVIII of the Act.

"OIG" means the Office of Inspector General within HHS.

"PRO" stands for Utilization and Quality Control Peer Review Organization.

"Secretary" means the Secretary of Health and Human Services.

"SNF" stands for skilled nursing facility.

"Social security benefits" means monthly cash benefits payable under section 202 or 223 of the Act.

"SSA" stands for Social Security Administration.

"United States" means the fifty States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

"U.S.C." stands for United States Code.

§ 1000.20 Definitions specific to Medicare.

As used in connection with the Medicare program, unless the context indicates otherwise—

"Beneficiary" means a person who is entitled to Medicare benefits.

"Carrier" means an entity that has a contract with HCFA to determine and make Medicare payments for Part B benefits payable on a charge basis and to perform other related functions.

"Entitled" means that an individual meets all the requirements for Medicare benefits.

"Hospital insurance benefits" means payments on behalf of, and in rare circumstances directly to, an entitled individual for services that are covered under Part A of Title XVIII of the Act.

"Intermediary" means an entity that has a contract with HCFA to determine and make Medicare payments for Part A or Part B benefits payable on a cost basis and to perform other related functions.

"Medicare Part A" means the hospital insurance program authorized under Part A of Title XVIII of the Act.

"Medicare Part B" means the supplementary medical insurance program authorized under Part B of Title XVIII of the Act.

"Provider" means a hospital, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or effective November 1, 1983 through September 30, 1986, a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has a similar agreement but only to furnish outpatient physical therapy or speech pathology services.

"Railroad retirement benefits" means monthly benefits payable to individuals under the Railroad Retirement Act of 1974 (45 U.S.C. beginning at section 231).

"Services" means medical care or services and items, such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of hospital or SNF facilities.

"Supplementary medical insurance benefits" means payment to or on behalf of an entitled individual for services covered under Part B of Title XVIII of the Act.

"Supplier" means a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare.

§ 1000.30 Definitions specific to Medicaid.

As used in connection with the Medicaid program, unless the context indicates otherwise—

"Applicant" means an individual whose written application for Medicaid has been submitted to the agency determining Medicaid eligibility, but has not received final action. This includes an individual (who need not be alive at the time of application) whose application is submitted through a representative or a person acting responsibly for the individual.

"Federal financial participation" (FFP) means the Federal Government's share of a State's expenditures under the Medicaid program.

"FMAP" stands for the Federal medical assistance percentage, which is used to calculate the amount of Federal share of State expenditures for services.

"Medicaid agency" or "agency" means the single State agency administering or supervising the administration of a State Medicaid plan.

"Provider" means any individual or entity furnishing Medicaid services under a provider agreement with the Medicaid agency.

"Recipient" means an individual who has been determined eligible for Medicaid.

"Services" means the types of medical assistance specified in sections 1905(a)(1) through (18) of the Act.

"State" means the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa and the Northern Mariana Islands.

"State plan" or *"the plan"* means a comprehensive written commitment by a Medicaid agency, submitted under section 1902(a) of the Act, to administer or supervise the administration of a Medicaid program in accordance with Federal requirements.

Subchapter B—OIG Authorities

PART 1001—PROGRAM INTEGRITY: MEDICARE

Subpart A—General Provisions

Sec.

Subpart B—Suspension, Exclusion, or Termination of Practitioners, Providers, Suppliers of Services, and Other Individuals

Suspensions, Exclusions or Termination on Basis of Fraud or Abuse

Suspensions on Basis of Conviction of Program-Related Crime

Reinstatement Procedures

Subpart C—Termination of Agreement and Reinstatement After Termination

Subpart D—Payment Denial Under the Prospective Payment System

Authority: Secs. 1102, 1128, 1842(j), 1862(d), 1862(e), 1866(b)(2) (D), (E) and (F), and 1871 of the Social Security Act (42 U.S.C. 1302, 1320a–7, 1395u(j), 1395y(d), 1395y(e), 1395cc(b)(2) (D), (E) and (F), and 1395hh), unless otherwise noted.

Subpart A—General Provisions

§ 1001.1 Scope and purpose.

This part sets forth provisions for the detection and prevention of fraud and abuse in the Medicare program. It implements statutory sections, specifically identified in each subpart, aimed at protecting the integrity of the Medicare program.

§ 1001.2 Definitions.

"Convicted" means that a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.

"Exclusion" means that items or services furnished by a specified practitioner, provider, or other supplier of services will not be reimbursed under Medicare.

"Furnished" refers to items and services provided directly by, or under the direct supervision of, or ordered by, a practitioner or other individual (either as an employee or in his or her own capacity), a provider, or other supplier of services. (For purposes of denial of reimbursement within this part, it does not refer to services ordered by one party but billed for and provided by or under the supervision of another.)

"HHS" means Department of Health and Human Services.

"OIG" means Office of Inspector General of the Department of Health and Human Services.

"Practitioner" means a physician or other individual licensed under State law to practice his or her profession.

"PRO" means Utilization and Quality Control Peer Review Organization as created by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248.

"Provider" means (a) hospital, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, Medicaid, or the social services programs, or (b) a clinic, a rehabilitation agency, or a public health agency that has a similar agreement, but only to furnish outpatient physical therapy or speech pathology services.

"Supplier" or *"supplier of services"* means an individual or entity, other than a provider or practitioner, that furnishes health care services under Medicare, Medicaid, or the social services programs.

"Suspension" means that items or services furnished by a specified party who has been convicted of a program related offense in a Federal, State, or

local court will not be reimbursed under Medicare or Medicaid.

§ 1001.3 Applicability of other regulations.

Subpart O of Part 405 of this title contains detailed procedures for hearings and reviews that are made available under this part for exclusions and terminations on the basis of fraud and abuse. Appeal procedures applicable to suspension based on a conviction for a program-related crime are specified in § 1001.128 of this Part.

Subpart B—Suspension, Exclusion, or Termination of Practitioners, Providers, Suppliers of Services, and Other Individuals

§ 1001.100 Basis and scope.

This subpart implements Sections 1128, 1842(j), and 1862 (d) and (e) of the Act. It sets forth criteria and procedures for (a) excluding practitioners, providers, and suppliers of services who have defrauded or abused the Medicare program or, for those physician practitioners who are not participating physicians, who have violated the billing restrictions of section 1842(j) of the Act, and (b) for suspending practitioners and other individuals convicted of crimes related to their participation in the delivery of medical care or services under the Medicare, Medicaid or the social services programs. It also specifies the appeal rights of a suspended or excluded individual and the procedures for reinstatement of excluded and suspended individuals. The procedures set forth in §§ 1001.101 through 1001.115 also apply to terminations of provider agreements under § 1001.201(a) (1), (2) or (3) of this chapter.

Suspensions, Exclusions or Termination on Basis of Fraud or Abuse

§ 1001.101 Bases for exclusions for fraud or abuse; exceptions.

(a) Payment will not be made under Medicare for items or services furnished by a practitioner, provider, or other supplier of services that the OIG determines has;

(1) Knowingly and willfully made or caused to be made any false statement or misrepresentation of a material fact in a request for payment under Medicare or for use in determining the right to payment under Medicare.

(2) Furnished items or services that are substantially in excess of the beneficiary's needs or of a quality that does not meet professionally recognized standards of health care; or

(3) Submitted or caused to be submitted bills or requests for payment containing charges (or costs) that are substantially in excess of its customary charges (or costs).

(b) The OIG's determination under paragraph (a)(2) of this section, that the items or services furnished were excessive or of unacceptable quality, will be made on the basis of reports, including sanction reports, from the following sources:

(1) The PSRO or PRO for the area served by the practitioner, provider, or other supplier of services;

(2) State or local licensing or certification authorities;

(3) Peer review committees of fiscal agents or contractors;

(4) State or local professional societies; or

(5) Other sources deemed appropriate by the OIG.

(c) *Exceptions.* (1) Notwithstanding the circumstances specified in paragraph (a)(2) of this section, HCFA will not deny Medicare payments if it has waived a disallowance on the grounds that the beneficiary and the practitioner, provider, or other supplier of services could not reasonably be expected to know that payment would not be made for a particular item or service (See § 405.330 of this title.)

(2) HCFA will not deny Medicare payment for bills or requests that are substantially in excess of customary charges or costs, if it finds the excess changes are justified by unusual circumstances or medical complications requiring additional time, effort, or expense in localities in which it is accepted medical practice to make an extra charge in such case.

§ 1001.102 Sanctions for violations of the freeze on physician charges.

(a) Whenever the OIG determines that a physician, who is not a participating physician under section 1842(h) of the Act, has during the statutory period of the freeze (1) provided services to a beneficiary and (2) knowingly and willfully billed that beneficiary for actual charges that are in excess of the physician's actual charges for the calendar quarter beginning on April 1, 1984, the OIG may exclude the physician from program participation for a period of up to five years, impose a monetary penalty or assessment against the physician, or both.

(b) If the OIG makes a determination under paragraph (a) of this section that involves a monetary penalty or assessment, the OIG will use the penalty determination, notification, effectuation, and appeal procedures contained in §§ 1003.100 through 1003.130 of this chapter.

(c) If the OIG makes a determination under paragraph (a) of this section and proposes to exclude a physician from Medicare program participation without imposing a monetary penalty or assessment, the OIG will use the determination, notification, effectuation, appeal, and reinstatement procedures contained in §§ 1001.100 through 1001.115 and 1001.130 through 1001.134.

§ 1001.103 Exclusion for violations of the freeze on physician charges.

(a) In excluding a physician under § 1001.102, the exclusion period determined under § 1001.114 may not exceed five years.

(b) The OIG will not impose an exclusion under § 1001.102 if it determines that the physician is the sole source of essential specialized service or a sole community physician.

§ 1001.105 Notice of proposed exclusion or termination for fraud or abuse.

(a) If the OIG proposes to deny reimbursement in accordance with § 1001.101, or to terminate a provider agreement in accordance with § 1001.201(a) (1), (2), or (3) of this chapter, it will send written notice of its intent and the reasons for the proposed exclusion or termination to the practitioner, provider or other supplier of services.

(b) Within 30 days of the date on the notice, the party may submit: (1) Documentary evidence and written argument against the proposed action; or (2) A written request to present evidence or argument orally to an OIG official.

(c) For good cause shown by the party, the OIG may extend the 30-day period.

§ 1001.107 Notice of exclusion or termination to affected party.

(a) If, after a party has exhausted the procedures specified in § 1001.105, the OIG decides to exclude the party under § 1001.101 or to terminate a provider agreement under § 1001.201(a) (1), (2), or (3) it will send written notice of its decision to the affected party at least 15 days before the decision becomes effective.

(b) The notice will state (1) the reasons for the decision; (2) the effective date; (3) the extent of its applicability to participation in the Medicare program; (4) the earliest date on which the OIG will accept a request for reinstatement; (5) the requirements and procedures for reinstatement; and (6) the appeal rights available to the excluded party.

(c) This decision and notice constitute an "initial determination" and a "notice of initial determination" for purposes of the administrative appeals procedures

specified in Subpart O of Part 405 of this title.

§ 1001.109 Notice to others regarding exclusion or termination.

Notice of exclusion or termination and the effective date will also be given to the public and, as appropriate, to:

(a) State Medicaid and title V agencies, State Medicaid Fraud Control Units, and PROs.

(b) Hospitals, skilled nursing facilities, home health agencies and health maintenance organizations (HMOs);

(c) Medical societies and other professional organizations;

(d) Contractors, health care prepayment plans and other affected agencies and organizations; and

(e) The State or local authority responsible for licensing or certifying the excluded party.

§ 1001.114 Duration of exclusion.

(a) The exclusion of a petitioner, provider, or other supplier of services will continue until the party is reinstated in accordance with §§ 1001.130 through 1001.136.

(b) The exclusion notice will specify the earliest date on which the excluded party may seek reinstatement. In setting that date, the OIG will consider:

(1) The number and nature of the program violations and other related offenses:

(2) The nature and extent of any adverse impact the violations have had on beneficiaries:

(3) The amount of any damages incurred by the Medicare program:

(4) Whether there are any mitigating circumstances:

(5) Any other facts bearing on the nature and seriousness of the violations or related offenses; and

(6) The previous sanction record of the excluded party under the Medicare or Medicaid program.

(c) For the effective date of termination of a provider agreement under § 1001.201(a) (1), (2), or (3), see § 1001.201(b) of this chapter.

§ 1001.115 Effect of exclusion.

(a) *Denial of payments during exclusion.* (1) Except as provided in paragraph (c) of this section, payment will not be made to an excluded practitioner, provider, or other supplier of services (that has accepted assignment of beneficiary claims), for items or services furnished on or after the effective date of exclusion specified in the exclusion notice.

(2) An assignment of a beneficiary's claim that is made on or after the effective date of exclusion will not be valid.

(b) *Denial of payment to beneficiaries.* If a beneficiary submits claims for items or services furnished by an excluded practitioner, provider, or other supplier of services after the effective date of the exclusion:

(1) HCFA will pay the first claim submitted by the beneficiary and immediately give notice of the exclusion.

(2) HCFA will not pay the beneficiary for items or services furnished by an excluded party more than 15 days after the date on the notice to the beneficiary or after the effective date of the exclusion, whichever is later.

(c) *Exceptions.* Payment is available for up to 30 days after the effective date of exclusion for—

(1) Inpatient hospital services (including inpatient psychiatric hospital services) or posthospital extended care services furnished to a beneficiary who was admitted before the effective date of exclusion; and

(2) Home health services and hospice care furnished under a plan established before the effective date of exclusion.

Suspensions on Basis of Conviction of Program-Related Crime

§ 1001.122 Bases for suspension for conviction of program-related crime and individuals affected.

(a) The OIG will suspend from participation in Medicare any party specified in paragraph (b) of this section who is convicted on or after October 25, 1977, of a criminal offense related to—

(1) Participation in the delivery of medical care or services under the Medicare, Medicaid, or the social services program; or

(2) Participation in the performance of management or administrative services relating to delivery of medical care or services under the Medicare, Medicaid, or the social services program.

(b) The suspension from participation in Medicare for conviction of a program-related crime, specified in paragraph (a) of this section, will apply to—

(1) Practitioners;

(2) Suppliers that are wholly owned by a convicted individual;

(3) Individuals who are employees, administrators, or operators of providers; and

(4) Any other individuals who, in any capacity, are receiving payment for providing services under Medicare, Medicaid, or the social services programs.

(c) The OIG will also require the State Medicaid agency to suspend any convicted party specified in paragraphs (a) and (b) of this section whether or not that party is eligible to participate in the Medicare program.

§ 1001.123 Notice to affected party of suspension for conviction of program-related crime.

(a) Whenever the OIG has conclusive information that a practitioner or other individual has been convicted of a crime related to his or her participation in the delivery of medical care or services under the Medicare, Medicaid, or the social services program, it will give the party written notice that he or she is suspended from participation in Medicare beginning 15 days from the date on the notice. In the case of a party who is not eligible to participate in Medicare, the OIG will provide written notice to the affected party that the State Medicaid agency will be required to suspend the party from Medicaid participation.

(b) The written notice will set forth:

(1) The basis for the suspension;

(2) The duration of the suspension and the factors considered in setting the duration;

(3) The requirements and procedure for reinstatement;

(4) The appeal rights;

(5) The fact that the State Medicaid agency is required to suspend the person from participation in the Medicaid program for the same period as he or she is suspended from Medicare participation.

§ 1001.124 Notice to others regarding suspension for conviction of program-related crime.

(a) The following groups will also be notified of the suspension concurrently with its notification to the suspended party:

(1) Any provider or supplier in which the suspended party is known to be serving as an employee, administrator, operator, or in which the party is serving in any other capacity and is receiving payment for providing services. The purpose of the notice is to inform the provider or supplier that Medicare payment will be denied for any services performed by the suspended party on or after the effective date of the suspension. However, the lack of this notice will not affect HCFA's ability to deny payment for these services;

(2) The State Medicaid agencies, in order that they can promptly suspend the party from participation in the Medicaid program (see § 1002.210 of the chapter);

(3) The State or local authority responsible for the licensing or certification of the suspended party;

(4) The public; and

(5) As appropriate—

(i) Title V agencies, States Medicaid Fraud Control Units, and PROs;

(ii) Hospitals, skilled nursing facilities, home health agencies, and health maintenance organizations (HMOs);

(iii) Medical societies and other professional organizations; and

(iv) Contractors, health care prepayment plans, and other affected agencies and organizations.

(b) The notice to the licensing or certifying authority will be accompanied by a request that the authority:

(1) Make appropriate investigations;

(2) Invoke any sanctions available under State law and the authority's policies; and

(3) Keep HCFA and the OIG fully and currently informed of any action it takes.

§ 1001.125 Duration of suspension.

(a) Suspension on the basis of a conviction of a program-related crime will continue until the suspended party is reinstated in accordance with §§ 1001.130 through 1001.136.

(b) The suspension notice will specify the earliest date on which the suspended individual may seek reinstatement. In setting that date, the OIG will consider:

(1) The number and nature of the program violations and other related offenses;

(2) The nature and extent of any adverse impact the violations have had on beneficiaries;

(3) The amount of the damages incurred by the Medicare, Medicaid, and the social services programs;

(4) Whether there are any mitigating circumstances;

(5) The length of the sentence imposed by the court;

(6) Any other facts bearing on the nature and seriousness of the program violations; and

(7) The previous sanction record of the suspended party under the Medicare or Medicaid program.

§ 1001.126 Effect of suspension.

(a) *Denial of payments to a suspended party.* (1) Payment will not be made to a suspended party (who has accepted assignment for the beneficiary's claims) for items and services furnished on or after the effective date of the suspension, except as provided in paragraph (e) of this section.

(2) An assignment of a beneficiary's claim that is made to an individual or supplier on or after the effective date of the suspension is not valid.

(b) *Denial of payments to a supplier that is wholly owned by a suspended party.* (1) Payment will not be made to a supplier (e.g., durable medical equipment supplier or laboratory) that is wholly owned by a suspended party for items or services furnished on or after the effective date of the suspension if the supplier has accepted assignment for the beneficiary's claim.

(2) An assignment of a beneficiary's claim that is made on or after the effective date of the suspension to a supplier that is wholly owned by a suspended party is not valid.

(c) *Denial of payments to a provider for services performed by a suspended party.* Payment will not be made to a provider for services performed, including services performed under contract, by a suspended party or by a supplier which is wholly owned by a suspended party, on or after the effective date of the suspension.

(d) *Denial of payment to beneficiaries.* If a beneficiary submits claims for items or services furnished by a suspended party or by a supplier which is wholly owned by a suspended party, on or after the effective date of the suspension—

(1) HCFA will pay the first claim submitted by the beneficiary and immediately give the beneficiary notice of the suspension.

(2) HCFA will not pay the beneficiary for items or services furnished more than 15 days after the date on the notice to the beneficiary.

(e) *Exceptions.* Payment is available for up to 30 days after the effective date of the suspension for—

(1) Inpatient hospital services (including inpatient psychiatric hospital services) or posthospital extended care furnished to a beneficiary who was admitted before the effective date of the suspension; and

(2) Home health services and hospice care furnished under a plan established before the effective date of the suspension.

§ 1001.128 Appeal procedures.

(a) A person suspended for conviction of a program-related crime, as specified in § 1001.122, may request a hearing before an Administrative Law Judge on the following issues:

(1) Whether he or she was, in fact, convicted;

(2) Whether the conviction was related to his or her participation in the delivery of medical care of services under the Medicare, Medicaid, or social services program; and

(3) Whether the length of the suspension is reasonable.

(b) A hearing under this section will be conducted in accordance with the procedures set forth in §§ 405.1531, 405.1533, 405.1534, 405.1540, 405.1541, 405.1543, and 405.1544 through 405.1558 of Subpart O of Part 405.15 of this title.

(c) If any party to the hearing is dissatisfied with the hearing decision, that party is entitled to request Appeals Council review of the decision as specified in §§ 405.1595 through 405.1559 of Subpart O of Part 405 of this title. A suspended party may also seek judicial review of the final administrative decision.

Reinstatement Procedures

§ 1001.130 Timing and method of request for reinstatement.

(a) A practitioner, provider, or supplier of services excluded from participation for fraud and abuse under § 1001.101 and a party suspended from participation for program-related crimes under § 1001.122 may request reinstatement at any time after the date specified in the notice of exclusion or suspension by submitting to the OIG or authorizing the OIG to obtain:

(1) Statements from private health insurers, indicating whether there have been any questionable claims submitted during the period of exclusion or suspension;

(2) Statements from peer review bodies, probation officers, where appropriate, or professional associates, as required by the OIG, attesting to their belief, supported by facts, that the violations that led to exclusion or conviction will not be repeated; and

(3) A statement from the affected party setting forth the reasons why he or she should be reinstated.

§ 1001.132 Criteria for action on request for reinstatement.

(a) *OIG criteria for action.* The OIG will not approve a request for reinstatement unless it is reasonably certain that the violations that led to exclusion or conviction will not be repeated. In making this determination, the OIG will consider, among other factors:

(1) Whether the applicant has been convicted in Federal, State or local court for activities related to his or her program participation; and

(2) Whether the State or local licensing authority has taken any adverse action against the party since the date of exclusion or suspension.

(b) *Additional criteria for providers requesting reinstatement.* When the OIG approves a request from a provider requesting reinstatement, such provider may not be reinstated until the OIG determines, based on the findings of HCFA, that the provider has fulfilled or has made satisfactory arrangements to fulfill all of the statutory and regulatory responsibilities specified in its agreement.

§ 1001.134 Notice of action on request for reinstatement.

(a) *Notice of approval of request.* If the OIG approves the request for reinstatement, it will:

(1) Give written notice to the excluded or suspended party specifying the date when program participation may resume; and

(2) Given notice to the public and, as appropriate, to Title V State agencies, State Medicaid agencies and Medicaid Fraud Control Units, hospitals, skilled nursing facilities, home health agencies, medical societies, other professional societies or associations, contractors, health care prepayment plans, health maintenance organizations (HMOs), PROs, the State or local licensing or certifying authority, and other affected organizations.

(b) *Notice of denial of request.* (1) If the OIG does not approve the request for reinstatement, it will give written notice to the party.

(2) Within 30 days of the date on the notice, the excluded or suspended party may submit:

(i) Documentary evidence and written argument against the continued exclusion or suspension; or

(ii) A written request to present evidence or argument orally to an OIG official. (The decision to continue the exclusion or suspension is not an initial determination under the provisions of Subpart O of Part 405 of this title.)

(c) *Action following consideration of additional evidence.* After evaluating any additional evidence submitted by the excluded or suspended party (or at the end of the 30 day period, if none is submitted), the OIG will send written notice:

(1) Confirming the denial, and indicating that a subsequent request for reinstatement will not be accepted until 6 months after the date of confirmation; or

(2) Approving reinstatement and specifying the date when program participation may be resumed. If the OIG approves reinstatement, the OIG will notify the public and, as appropriate, the agencies and institutions as specified in paragraph (a)(2) of this section.

(d) The OIG must automatically reinstate a physician excluded only on the basis of § 1001.102 if that exclusion has been in effect for five (5) years.

§ 1001.136 Reversed or vacated convictions of program related crime.

(a) The OIG will reinstate a suspended party whose conviction has been reversed or vacated.

(b) If a reinstatement is made under paragraph (a) of this section, HCFA will make payment, either to the party or the beneficiary, if the claim was not assigned, for services covered under Medicare that are furnished or performed during the period of suspension.

Subpart C—Termination of Agreement and Reinstatement After Termination

§ 1001.201 Termination by the OIG.

(a) *Basis for termination.* The OIG may terminate the agreement of any provider if the OIG finds that any of the following failings can be attributed to that provider:

(i) It has knowingly and willfully made, or caused to be made, any false statement or representation of a material fact for use in an application or request for payment under Medicare.

(ii) It has submitted, or caused to be submitted, requests for Medicare payment of amounts that substantially exceed the costs it incurred in furnishing the services for which payment is requested.

(iii) It has furnished services that the OIG has determined to be substantially in excess of the needs of individuals or of a quality that fails to meet professionally recognized standards of health care. The OIG will not terminate a provider agreement under paragraph (a) if HCFA has waived a disallowance with respect to the services in question on the grounds that the provider and the beneficiary could not reasonably be expected to know the payment would not be made. (The rules for determining such lack of knowledge are set forth in §§ 405.334 and 405.336 of this title.)

(b) *Notice of termination.* (1)The OIG will give the provider notice of termination at least 15 days before the effective date of termination of the agreement, and will concurrently give notice of termination to the public. The notice will state the reasons for, and the effective date of, the termination, and explain to what extent services may continue after that date, in accordance with the exceptions set forth in § 1001.211.

(c) *Appeal by the provider.* A provider may appeal a termination of its agreement by the OIG, in accordance with Subpart O of Part 405 of this title. The termination of a provider agreement by the OIG is subject to the additional procedures specified in §§ 1001.105 through 1001.109 of this chapter for notice and appeals.

§ 1001.211 Exceptions to effective date of termination.

Payment is available for up to 30 days after the effective date of termination for—

(a) Inpatient hospital services (including inpatient psychiatric hospital services) and posthospital extended care services furnished to a beneficiary who was admitted before the effective date of termination; and

(b) Home health services and hospice care furnished under a plan established before the effective date of termination. [1]

§ 1001.221 Reinstatement after termination.

When a provider agreement has been terminated by the OIG under § 1001.201, or by HCFA under § 489.53 of this title, a new agreement with that provider will not be accepted unless the OIG or HCFA, as appropriate, finds—

(a) That the reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur; and

(b) That the provider has fulfilled, or has made satisfactory arrangements to fulfill, as of the statutory and regulatory responsibilites of its previous agreement.

Subpart D—Payment Denial Under the Prospective Payment System

§ 1001.301 Denial of payment as a result of admissions and quality review.

(a) A determination under § 412.48(a) of this title, related to a pattern of inappropriate admissions and billing practices that have the effect of circumventing the prospective payment system, will be referred by HCFA to the OIG for a determination in accordance with section 1866(b)(2) of the Act. The determination will be effective in the manner provided in section 1866(b)(3) and (4) of the Act, and regulations in subpart C of this Part, with respect to terminations of agreements, and will remain in effect until the OIG finds and gives reasonable notice to the public and that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(b) Any party to a determination made by the OIG under paragraph (a) of this section, who is dissatisfied with that determination, is entitled to reasonable notice and opportunity for a hearing to the same extent as provided in section 205(b) of the Act and to judicial review of the final decision after hearing as provided in section 205(g) of the Act.

(c) The OIG will promptly notify each Medicaid agency of any determination

[1] For termination before July 18, 1984 payment was available through the calendar year in which the termination was effective.

made under paragraph (a) of this section.

PART 1002—PROGRAM INTEGRITY—MEDICAID

Subpart A—General Provisions

Subpart B—Exclusion of Providers, and Suspension of Practitioners and Other Individuals

Exclusions on Basis of Fraud and Abuse

Suspensions on Basis of Conviction of Program-Related Crimes

Reinstatement Procedures

Subpart C—State Medicaid Fraud Control Units

Authority: Secs. 1102, 1124, 1126, 1128, 1902(a)(4)(A), 1902(a)(30), 1902(a)(39), 1903(a)(6), 1903(b)(3), 1903(i)(2), 1903(n), and 1903(q) of the Social Security Act; 42 U.S.C. 1302, 1320a–3, 1320a–5, 1320a–7, 1396a(a)(4)(A), 1396a(30), 1396a(39), 1396b(a)(6), 1396b(b)(3), 1396b(i)(2), 1396b(n), and 1396b(q).

Subpart A—General Provisioins

§ 1002.1 Basis and purpose.

(a) This part sets forth requirements for the prevention of fraud and abuse in the Medicaid program and implements specific statutory provisions aimed at protecting the integrity of the program.

(b) Subpart B is based on sections 1126, 1128, 1902(a)(4)(A), 1902(a)(30), 1902(a)(39) and 1903(i)(2) of the Social Security Act. It requires Medicaid agencies to—

(1) Have the ability to exclude from program reimbursement any provider that defrauds or abuses the Medicaid or Medicare program; and

(2) Suspend any individual receiving reimbursement under the Medicaid program who has been convicted of a crime related to delivery of medical care or services under the Medicare, Medicaid, or social services programs.

(c) Subpart C implements sections 1903(a)(6), 1903(b)(3), and 1903(q) of the Social Security Act, and prescribes requirements for the establishment and operation of State Medicaid fraud control units. It also details conditions that must be met in order for costs of the fraud control units to quality for 90 percent Federal financial participation (FFP).

§ 1002.2 Definitions.

As used in Suparts B and C of this part, unless the context indicates otherwise—

"Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecesary cost to the Medicaid program.

"Conviction" or "Convicted" means that a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.

"Exclusion" means that items or services furnished by a specific provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

"Furnished" refers to items and services provided directly by, or under the direct supervision of, or ordered by, a practitioner or other individual (either as an employee or in his or her own capacity), a provider, or other supplier of services. (For purposes of denial of reimbursement within this Part, it does not refer to services ordered by one party but billed for and provided by or under the supervision of another.)

"Practitioner" means a physician or other individual licensed under State law to practice his or her profession.

"PRO" means Utilization and Quality Control Peer Review Organization as created by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248.

"PSRO" stands for Professional Standards Review Organization.

"Suspension" means that items or services furnished by a specified provider who has been convicted of a program related offense in a Federal State, or local court will not be reimbursed under Medicaid.

§ 1002.3 Disclosure by providers: Information on persons convicted of crimes.

(a) *Information that must be disclosed.* Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:

(1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

(2) Has been convicted of a cirminal offense related to that person's in volvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

(b) *Notification to Inspector General.* (1) The Medicaid agency must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information.

(2) The agency must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program.

(c) *Denial or termination of provider participation.* (1) The Medicaid agency may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established

under Medicare, Medicaid or the Title XX Services Program.

(2) The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.

Subpart B—Exclusion of Providers, and Suspension of Practitioners and Other Individuals

§ 1002.200 State plan requirement.

The plan must provide that the requirements of this subpart are met. However, the provisions of these regulations are minimum requirements. The agency may impose broader sanctions if it has the authority to do so under State law.

§ 1002.203 Exclusion of Medicaid providers for fraud and abuse.

(a) *Basis for exclusion.* The agency must have administrative procedures which enable the agency to exclude from Medicaid reimbursement a provider who it determines has:

(1) Knowingly and willfully made or caused to be made any false statement or misrepresentation of material fact in claiming, or use in determining the right to, payment under Medicaid.

(2) Furnished or ordered services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized standards for health care; or

(3) Submitted or caused to be submitted to the Medicaid program bills or requests for payment containing charges or costs that are substantially in excess of customary charges or costs. However, the agency must not impose an exclusion under this section if it finds the excess charges are justified by unusual circumstances or medical complications requiring additional time, effort, or expense in localities in which it is accepted medical practice to make an extra charge in such case.

(b) *Reports to be considered.* The agency may base its determination that services were excessive or of unacceptable quality on reports, including sanction reports, from any of the following sources:

(1) The PRO for the area served by the provider;

(2) State or local licensing or certification authorities;

(3) Peer review committees of fiscal agents or contractors;

(4) State or local professional societies; or

(5) Other sources deemed appropriate by the Medicaid agency or the OIG.

§ 1002.204 Notice of proposed exclusion for fraud and abuse.

If the agency proposes to exclude a provider under § 1002.203 it must send the provider written notice stating the reasons for the proposed exclusion and the right to review.

§ 1002.205 Right to review.

Before imposing an exclusion, the agency must give the provider the opportunity to submit documents and written argument against the exclusion. However, the provider must be given any additional appeals rights under procedures established by the State.

§ 1002.206 Notice of exclusion for fraud and abuse.

After the review, if the agency makes a final decision to exclude—

(a) The agency must send the provider written notice 15 days before the exclusion becomes effective;

(b) The notice must state—

(1) The reasons for the decision;

(2) The effective date;

(3) The effect of the exclusion on the party's participation in the Medicaid program;

(4) The earliest date in which the agency will accept a request for reinstatement (see §§ 1002.232 and 1002.234 for reinstatement procedures); and

(5) The requirements and procedures for reinstatement.

(c) The agency must also give notice of the exclusion and the effective date to the OIG, HCFA, the public, and, as appropriate, to—

(1) Recipients;

(2) PROs;

(3) Providers and organizations;

(4) Medical societies and other professional organizations;

(5) State licensing boards and affected State and local agencies and organizations; and

(6) Medicare carriers and intermediaries.

§ 1002.207 Denial of payment and FFP: Parties excluded under Medicaid.

(a) *Denial of payment.* The agency must not make payment under Medicaid for items or services furnished by a provider who has been excluded from the Medicaid program in accordance with § 1002.203.

(b) *Denial of FFP.* FFP is not available in payments under any State plan for services furnished by a provider who has been excluded from the Medicaid program.

(c) *Duration of exclusion.* The exclusion will continue until the provider is reinstated in accordance with §§ 1002.230 through 1002.236.

(d) *When FFP will be reinstated.* FFP will be available for services furnished by a Medicaid provider after reinstatement in the Medicaid program.

§ 1002.208 Denial of FFP: Parties excluded or terminated under Medicare for fraud and abuse.

(a) *Denial of FFP.* FFP is not available in payments for services furnished by a Medicaid provider while that provider is excluded or terminated from participation, or otherwise sanctioned, because of fraud and abuse under the Medicare program under § 1001.101 of this chapter.

(b) *Effective date of denial.* Except as specified in paragraph (c) of this section, the denial of FFP will apply to services furnished on or after the effective date of the exclusion from Medicare.

(c) *Exception: FFP available in payment made during exclusion or after termination.* Payment is available for up to 30 days after the effective date of the exclusion or termination for—

(1) Inpatient hospital services (including inpatient psychiatric hospital services) and skilled nursing facility and intermediate care facility services furnished to a beneficiary who was admitted before the effective date of the exclusion or termination; and

(2) Home health services and hospital care furnished under a plan established before the effective date of the exclusion or termination.

(d) *When FFP will be reinstated.* FFP will be available for services furnished by a Medicaid provider after reinstatement in the Medicare program.

Suspensions on Basis of Conviction of Program-Related Crimes

§ 1002.210 Bases for suspension for conviction of program-related crimes.

The agency must suspend from the Medicaid program any party who has been suspended from participation in Medicare under § 1001.122 of this chapter for conviction of a program-related crime. The agency must also suspend any convicted party who is not eligible to participate in Medicare whenever the OIG directs such action.

§ 1002.211 Duration of suspension.

(a) The suspension under Medicaid must be effective on the date established by the OIG for suspension under Medicare, and must be for the same period as the Medicare suspension. In the case of a convicted party who is not eligible to participate in Medicare, the suspension will be effective on the date and for the period established by the OIG.

(b) The agency may impose a sanction under its own sanction authorities which is effective before, or extends beyond, the mandatory suspension period under paragraph (a) of this section.

§ 1002.212 Notification of State or local convictions of crimes againt Medicaid.

(a) The agency must notify the OIG whenever a State or local court has entered a judgment of conviction against an individual who is receiving reimbursement under Medicaid, for a criminal offense related to participation in the delivery of medical care or services under the Medicaid program.

(b) If the agency was involved in the investigation or prosecution of the case, it must send notice within 15 days after the conviction.

(c) If the agency was not so involved, it must give notice within 15 days after it learns of the conviction.

(Approved by the Office of Management and Budget under control number 0938–0076)

§ 1002.213 Effect of suspension.

(a) *Denial of payment.* Except as specified in paragraph (b) of this section, the agency must not make any payment under the plan for services furnished directly by, or under the supervision of, a suspended party during the period of the suspension.

(b) *Circumstances under which payment may be made after a suspension.* Payment is available for up to 30 days after the effective date of the suspension for—

(1) Inpatient hospital services (including inpatient psychiatric hospital services) and skilled nursing facility and intermediate care facility services furnished to a beneficiary who was admitted before the effective date of the suspension; and

(2) Home health services and hospital care funished under a plan established before the effective date of the suspension.

§ 1002.214 Waiver of suspension of parties.

(a) *Request.* The agency may request the OIG to waive suspension of a party under § 1002.210 if it concludes that, because of the shortage of providers or other health care personnel in the area, individuals eligible to receive Medicaid benefits would be denied adequate access to medical care.

(b) *Notice of waiver of suspension.* The OIG will notify the agency if and when it waives suspension in response to the agency's request.

Reinstatement Procedures

§ 1002.230 Reinstatement of parties suspended under Medicare.

(a) The agency may not reinstate in the Medicaid program a party that has been suspended from Medicare or suspended at the direction of the OIG until the OIG notifies the agency that the party may be reinstated.

(b) If the OIG makes a determination to reinstate a party under Medicare, the agency, upon notification from the OIG, must automatically reinstate the party under Medicaid effective on the date of reinstatement under Medicare, unless a longer period of suspension was established in accordance with the State's own authorities and procedures.

§ 1002.232 Basis for reinstatement after exclusion.

(a) The provisions of this section and § 1002.234 apply to the reinstatement in the Medicaid program of all parties excluded in accordance with § 1002.203, if a State affords reinstatement opportunity to those parties.

(b) A party who has been excluded from Medicaid may be reinstated only by the Medicaid agency that imposed the exclusion.

(c) A party may submit to the agency a request for reinstatement at any time after the date specified in the notice of exclusion.

(d) In setting the earliest date on which it will consider a request for reinstatement, the agency must consider—

(1) The number and nature of the program violations and other related offenses;

(2) The nature and extent of any adverse impact the violations have had on recipients;

(3) The amount of any damages;

(4) Whether there are any mitigating circumstances; and

(5) Any other facts bearing on the nature and seriousness of the program violations or related offenses.

§ 1002.234 Action on request for reinstatement.

(a) *Criteria for approving reinstatement request.* The agency may grant reinstatement only if it is reasonably certain that the violation(s) that led to exclusion will not be repeated. In making this determination, the agency will consider, among other factors—

(1) Whether the party has been convicted in a Federal, State, or local court of other offenses related to participation in the Medicare or Medicaid program which were not considered during the development of the exclusion; and

(2) Whether the State or local licensing authorities have taken any adverse action against the party for offenses related to participation in the Medicare or Medicaid program which were not considered during the development of the exclusion.

(b) *Notice of action on request.* (1) If the agency approves the request for reinstatement, it must give written notice to the excluded party, and to all others who were informed of the exclusion in accordance with § 1002.206, specifying the date on which Medicaid program participation may resume.

(2) If the agency does not approve the request for reinstatement, it will notify the excluded party of its decision.

Subpart C—State Medicaid Fraud Control Units

§ 1002.301 Definitions.

As used in this subpart, unless otherwise indicated by the context:

"Employ" or "employee", as the context requires, means full-time duty intended to last at least a year. It includes an arrangement whereby an individual is on full-time detail or assignment to the unit from another government agency, if the detail or assignment is for a period of at least 1 year and involves supervision by the unit.

"Provider" means an individual or entity which furnishes items or services for which payment is claimed under Medicaid.

"Unit" means the State Medicaid fraud control unit.

§ 1002.303 Scope and purpose.

This subpart implements sections 1903(a)(6), 1903(b)(3), and 1903(q) of the Social Security Act, as amended by the Medicare-Medicaid Anti-fraud and Abuse Amendments (Pub. L. 95–142 of October 25, 1977). The statute authorizes the Secretary to pay a State 90 percent of the costs of establishing and operating a State Medicaid fraud control unit, as defined by the statute, for the purpose of eliminating fraud in the State Medicaid program.

§ 1002.305 Basic requirement.

A State Medicaid fraud control unit must be a single identifiable entity of the State government certified by the Secretary as meeting the requirements of §§ 1002.307 through 1002.313 of this chapter.

§ 1002.307 Organization and location requirements.

Any of the following three alternatives is acceptable:

(a) The unit is located in the office of the State attorney general or another department of State government which has statewide authority to prosecute individuals for violations of criminal laws with respect to fraud in the provision or administration of medical assistance under a State plan implementing Title XIX of the Act; or

(b) If there is no State agency with statewide authority and capability for criminal fraud prosecutions, the unit has established formal procedures which assure that the unit refers suspected cases of criminal fraud in the State Medicaid program to the appropriate State prosecuting authority or authorities, and provides assistance and coordination to such authority or authorities in the prosecution of such cases; or

(c) The unit has a formal working relationship with the office of the State attorney general and has formal procedures for referring to the attorney general suspected criminal violations occurring in the State Medicaid program and for effective coordination of the activities of both entities relating to the detection, investigation and prosecution of those violations. Under this requirement, the office of the State attorney general must agree to assume responsibility for prosecuting alleged criminal violations referred to it by the unit. However, if the attorney general finds that another prosecuting authority has the demonstrated capacity, experience and willingness to prosecute an alleged violation, he or she may refer a case to that prosecuting authority, as long as the Attorney General's Office maintains oversight responsibility for the prosecution and for coordination between the unit and the prosecuting authority.

§ 1002.309 Relationship to, and agreement with, the Medicaid agency.

(a) The unit must be separate and distinct from the Medicaid agency.

(b) No official of the Medicaid agency shall have authority to review the activities of the unit or to review or overrule the referral of a suspected criminal violation to an appropriate prosecuting authority.

(c) The unit shall not receive funds paid under this subpart either from or through the Medicaid agency.

(d) The unit shall enter into an agreement with the Medicaid agency under which the Medicaid agency will agree to comply with all requirements of § 455.21(a)(2) of this title.

§ 1002.311 Duties and responsibilities of the unit.

(a) The unit shall conduct a statewide program for investigating and prosecuting (or referring for prosecution) violations of all applicable State laws pertaining to fraud in the administration of the Medicaid program, the provision of medical assistance, or the activities of providers of medical assistance under the State Medicaid plan.

(b) The unit shall also review complaints alleging abuse or neglect of patients in health care facilities receiving payments under the State Medicaid plan and may review complaints of the misappropriation of patient's private funds in such facilities.

(1) If the initial review indicates substantial potential for criminal prosecution, the unit shall investigate the complaint or refer it to an appropriate criminal investigative or prosecutive authority.

(2) If the initial review does not indicate a substantial potential for criminal prosecution, the unit shall refer the complaint to an appropriate State agency.

(c) If the unit, in carrying out its duties and responsibilities under paragraphs (a) and (b) of this section, discovers that overpayments have been made to a health care facility or other provider of medical assistance under the State Medicaid plan, the unit shall either attempt to collect such overpayment or refer the matter to an appropriate State agency for collection.

(d) Where a prosecuting authority other than the unit is to assume responsibility for the prosecution of a case investigated by the unit, the unit shall insure that those responsible for the prosecutive decision and the preparation of the case for trial have the fullest possible opportunity to participate in the investigation from its inception and will provide all necessary assistance to the prosecuting authority throughout all resulting prosecutions.

(e) The unit shall make available to Federal investigators or prosecutors all information in its possession concerning fraud in the provision or administration of medical assistance under the State plan and shall cooperate with such officials in coordinating any Federal and State investigations or prosecutions involving the same suspects or allegations.

(f) The unit shall safeguard the privacy rights of all individuals and shall provide safeguards to prevent the misuse of information under the unit's control.

§ 1002.313 Staffing requirements.

(a) The unit shall employ sufficient professional, administrative, and support staff to carry out its duties and responsibilities in an effective and efficient manner. The staff must include:

(1) One or more attorneys experienced in the investigation or prosecution of civil fraud or criminal cases, who are capable of giving informed advice on applicable law and procedures and providing effective prosecution or liaison with other prosecutors;

(2) One or more experienced auditors capable of supervising the review of financial records and advising or assisting in the investigation of alleged fraud;

(3) A senior investigator with substantial experience in commercial or financial investigations who is capable of supervising and directing the investigative activities of the unit.

(b) The unit shall employ, or have available to it, professional staff who are knowledgeable about the provision of medical assistance under title XIX and about the operation of health care providers.

§ 1002.315 Applications, certification, and recertification.

(a) *Initial application.* In order to receive FFP under this subpart, the unit must submit to the Secretary, an application approved by the Governor, containing the following information and documentation.

(1) A description of the applicant's organization, structure, and location within State government, and an indication of whether it seeks certification under § 1002.307 (a), (b) or (c);

(2) A statement from the State attorney general that the applicant has authority to carry out the functions and responsibilities set forth in this subpart. If the applicant seeks certification under § 1002.307(b), the statement must also specify either that there is no State agency with the authority to exercise statewide prosecuting authority for the violations with which the unit is concerned, or that, although the State attorney general may have common law authority for statewide criminal prosecutions, he or she has not exercised that authority;

(3) A copy of whatever memorandum of agreement, regulation, or other document sets forth the formal procedures required under § 1002.307(b), or the formal working relationship and procedures required under § 1002.307(c);

(4) A copy of the agreement with the Medicaid agency required under § 1002.309;

(5) A statement of the procedures to be followed in carrying out the functions and responsibilities of this subpart;

(6) A projection of the caseload and a proposed budget for the 12-month period for which certification is sought; and

(7) Current and projected staffing, including the names, education, and experience of all senior professional staff already employed and job descriptions, with minimum qualifications, for all professional positions.

(b) *Conditions for, and notification of certification.* (1) The Secretary will approve an application only if he or she has specifically approved the applicant's formal procedures under § 1002.307 (b) or (c), if either of those provisions is applicable, and has specifically certified that the applicant meets the requirements of § 1002.307;

(2) The Secretary will promptly notify the applicant whether the application meets the requirements of this subpart and is approved. If the application is not approved, the applicant may submit an amended application at any time. Approval and certification will be for a period of 1 year.

(c) *Conditions for recertification.* In order to continue receiving payments under this subpart, a unit must submit a reapplication to the Secretary at least 60 days prior to the expiration of the 12-month certification period. A reapplication must:

(1) Advise the Secretary of any changes in the information or documentation required under paragraphs (a) (1) through (5) of this section;

(2) Provide projected caseload and proposed budget for the recertification period; and

(3) Include or incorporate by reference the annual report required under § 1002.317.

(d) *Basis for recertification.* (1) The Secretary will consider the unit's reapplication, the reports required under § 1002.317, and any other reviews or information he or she deems necessary or warranted, and will promptly notify the unit whether he or she has approved the reapplication and recertified the unit.

(2) In reviewing the reapplication, the Secretary will give special attention to whether the unit has used its resources effectively in investigating cases of possible fraud, in preparing cases for prosecution, and in prosecuting cases or cooperating with the prosecuting authorities.

(Approved by the Office of Management and Budget under control number 0990–0162)

§ 1002.317 Annual report.

At least 60 days prior to the expiration of the certification period, the unit shall submit to the Secretary a report covering the last 12 months (the first 9 months of the certification period for the first annual report), and containing the following information:

(a) The number of investigations initiated and the number completed or closed, categorized by type of provider;

(b) The number of cases prosecuted or referred for prosecution; the number of cases finally resolved and their outcomes; and the number of cases investigated but not prosecuted or referred for prosecution because of insufficient evidence;

(c) The number of complaints received regarding abuse and neglect of patients in health care facilities; the number of such complaints investigated by the unit; and the number referred to other identified State agencies.

(d) The number of recovery actions initiated by the unit; the number of recovery actions referred to another agency; the total amount of overpayments identified by the unit; and the total amount of overpayments actually collected by the unit;

(e) The number of recovery actions initiated by the Medicaid agency under its agreement with the unit; and the total amount of overpayments actually collected by the Medicaid agency under this agreement;

(f) Projections for the succeeding 12 months for items listed in paragraphs (a) through (e) of this section;

(g) The costs incurred by the unit;

(h) A narrative that evaluates the unit's performance; describes any specific problems it has had in connection with the procedures and agreements required under this subpart; and discusses any other matters that have impaired its effectiveness.

(Approved by the Office of Management and Budget under control number 0990–0162)

§ 1002.319 Federal financial participation (FFP).

(a) *Rate of FFP.* Subject to the limitation of this section, the Secretary will reimburse each State by an amount equal to 90 percent of the costs incurred by a certified unit which are attributable to carrying out its functions and responsibilities under this subpart.

(b) *Retroactive certification.* The Secretary may grant certification retroactive to the date on which the unit first met all the requirements of the statute and of this subpart. For any quarter with respect to which the unit is certified, the Secretary will provide reimbursement for the entire quarter.

(c) *Amount of FFP.* FFP for any quarter shall not exceed the higher of $125,000 or one-quarter of 1 percent of the sums expended by the Federal, State, and local governments during the previous quarter in carrying out the State Medicaid program.

(d) *Costs subject to FFP.* FFP is available under this subpart for the expenditures attributable to the establishment and operation of the unit, including the cost of training personnel employed by the unit. Reimbursement shall be limited to costs attributable to the specific responsibilities and functions set forth in this subpart in connection with the investigation and prosecution of suspected fraudulent activities and the review of complaints of alleged abuse or neglect of patients in health care facilities. Establishment costs are limited to clearly identifiable costs of personnel that:

(1) Devote full time to the establishment of the unit which does achieve certification; and

(2) Continue as full-time employees after the unit is certified. All establishment costs will be deemed made in the first quarter of certification.

(e) *Costs not subject to FFP.* FFP is not available under this subpart for expenditures attributable to:

(1) The investigation of cases involving program abuse or other failures to comply with applicable laws and regulations, if these cases do not involve substantial allegations or other indications of fraud;

(2) Efforts to identify situations in which a question of fraud may exist, including the screening of claims, analysis of patterns of practice, or routine verification with recipients of whether services billed by providers were actually received;

(3) The routine notification of providers that fraudulent claims may be punished under Federal or State law;

(4) The performance by a person other than a full-time employee of the unit of any management function for the unit, any audit or investigation, any professional legal function, or any criminal, civil or administrative prosecution of suspected providers;

(5) The investigation or prosecution of cases of suspected recipient fraud not involving suspected conspiracy with a provider; or

(6) Any payment, direct or indirect, from the unit to the Medicaid agency, other than payments for the salaries of employees on detail to the unit.

§ 1002.321 Other applicable HHS regulations.

Except as otherwise provided in this subpart, the following regulations from 45 CFR Subtitle A apply to grants under this subpart:

Subpart C of Part 16—Department Grant Appeals Process—Special Provisions Applicable To Reconsideration of Disallowances (note that this applies only to disallowance determinations and not to any other determinations, e.g., over certification or recertification)
Part 74—Administration of Grants
Part 75—Informal Grant Appeals Procedures
Part 80—Nondiscrimination Under Programs Receiving Federal Assistance Through the Department of Health and Human Services; Effectuation of Title VI of the Civil Rights Act of 1964
Part 81—Practice and Procedure for Hearings Under 45 CFR Part 80
Part 84—Nondiscrimination on the Basis of Handicap in Programs and Activities Receiving or Benefiting From Federal Financial Assistance

PART 1003—CIVIL MONEY PENALTIES AND ASSESSMENTS

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Authority: Secs. 1102, 1128, 1128A and 1842(j) of the Social Security Act (42 U.S.C. 1302, 1320a–7, 1320a–7a, and 1995u(j)).

§ 1003.100 Basis and purpose.

(a) *Basis.* This part implements sections 1128(c), 1128A, and 1842(j) of the Social Security Act (42 U.S.C. 1320a–7c, 1320a–7a, and 1395u(j)).

(b) *Purpose.* This part (1) establishes procedures for imposing civil money penalties and assessments against persons who have submitted certain prohibited claims under the Medicare, Medicaid, or the Maternal and Child Health Services Block Grant programs; (2) establishes procedures for suspending from the Medicare and Medicaid programs, persons against whom a civil money penalty or assessment has been imposed; and (3) specifies the appeal rights of persons subject to a penalty or assessment.

§ 1003.101 Definitions.

For purposes of this part:

Act means the Social Security Act.

Agent includes a Medicare fiscal intermediary or carrier, a Medicaid fiscal agent, or any other claims processing agent under the Medicare, Medicaid, or Maternal and Child Health Services Block Grant program.

ALJ means an Administrative Law Judge.

Assessment means the amount described in § 1003.104, and includes the plural of that term.

Claim means an application submitted by a person to an agency of the United States or of a State, or an agent thereof, for payment for:

(a) An item or service for which payment may be made under Medicare, or

(b) An item or service for which medical assistance is provided under a State plan for medical assistance, or

(c) An item or service for which payment may be made under the Maternal and Child Health Services Block Grant program.

Department means the Department of Health and Human Services.

General Counsel means the General Counsel of the Department or his or her designees.

HCFA means the Health Care Financing Administration.

Inspector General means the Inspector General of the Department or his or her designees.

Item or service includes (a) any item, device, medical supply or service claimed to have been provided to a patient and listed in an itemized claim for program payment or a request for payment, and (b) in the case of a claim based on costs, any entry or omission in a cost report, books of account or other documents supporting the claim.

Maternal and Child Health Services Block Grant program means the program authorized under Title V of the Act.

Medicaid means the program of grants to the States for medical assistance authorized under title XIX of the Act.

Medicare means the program of health insurance for the aged and disabled authorized under Title XVIII of the Act.

Penalty means the amount described in § 1003.103 and includes the plural of that term.

Person means an individual, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private.

Program means the Medicare, Medicaid or Maternal and Child Health Services Block Grant program.

Request for payment means an application submitted by a person to any person for payment for an item or service covered under the Medicare, Medicaid or Maternal and Child Health Services Block Grant program.

Respondent means the person upon whom the Secretary has imposed, or proposes to impose, a penalty or assessment.

Secretary means the Secretary of the Department or his or her designees.

State includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands.

Suspension means the temporary barring or permanent exclusion of a person from participation in the Medicare or Medicaid programs under section 1128(b) of the Social Security Act.

§ 1003.102 Basis for civil money penalties and assessments.

(a) The OIG may impose a penalty and assessment against any person whom it determines in accordance with this part has presented or caused to be presented a claim which is for an item or service:

(1) That the person knew or had reason to know was not provided as claimed; or

(2) For which no payment could be made under the program under which it was submitted because:

(i) The person had been excluded under section 1128 of the Act (42 U.S.C. 1320a–7);

(ii) The person had been excluded from eligibility to provide services on a reimbursement basis under section

1160(b) of the Act as that section read prior to enactment of Pub. L. 97-248 (42 U.S.C. 1320c-9(b));

(iii) Payment had been prohibited under Title XVIII of the Act because of a determination under section 1862(d) of the Act (42 U.S.C. 1395y(d)); or

(iv) The Secretary had initiated termination proceedings against the person pursuant to a determination by the Secretary under section 1866(b)(2) of the Act (42 U.S.C. 1395cc(b)(2)).

(b) The OIG may impose a penalty against any person whom it determines in accordance with this part:

(1) Has presented or caused to be presented a request for payment in violation of the terms of:

(i) An agreement to accept payments on the basis of an assignment under section 1842(b)(3)(B)(ii) of the Act;

(ii) An agreement with a State agency not to charge a person for an item or service in excess of the amount permitted to be charged; or

(iii) An agreement to be a participating physician or supplier under section 1842(h)(1); or

(2) Is a non-participating physician under section 1842(j) of the Act and has knowingly and willfully billed individuals enrolled under Part B of Title XVIII of the Act, during the statutory period of the freeze, for actual charges in excess of such physicians, actual charges for the calendar quarter beginning on April 1, 1984.

(c)(1) In any case in which it is determined that more than one person was responsible for presenting or causing to be presented a claim as described in paragraph (a) of this section, each such person may be held liable for the penalty prescribed by this part, and an assessment may be imposed against any one such person or jointly and severally against two or more such persons, but the aggregate amount of the assessments collected may not exceed the amount that could be assessed if only one person was responsible.

(2) In any case in which it is determined that more than one person was responsible for presenting or causing to be presented a request for payment described in paragraph (b) of this section, each such person may be held liable for the penalty prescribed by this part.

§ 1003.103 Amount of penalty.

The OIG may impose a penalty of not more than $2,000 for each item of service that is subject to a determination under § 1003.102.

§ 1003.104 Amount of assessment.

A person subject to a penalty determined under § 1003.102(a) may be subject, in addition, to an assessment of not more than twice the amount claimed for each item or service which was a basis for the penalty. The assessment is in lieu of damages sustained by the Department or a State agency because of that claim.

§ 1003.105 Suspension from participation in Medicare or Medicaid.

(a) A person subject to a penalty or assessment determined under § 1003.102 may, in addition, be suspended from participation in Medicare for a period of time determined under § 1003.107. The OIG may require the appropriate State agency to suspend the person from the Medicare program for a period he shall specify. The State agency may request the Secretary to waive suspension of a person from the Medicaid program under this section if it concludes that, because of the shortage of providers or other health care personnel in the area, individuals eligible to receive Medicaid benefits would be denied access to medical care or that such individuals would suffer hardship. The Secretary will notify the State agency if and when the Secretary waives suspension in response to such a request.

(b) Any suspension under this section shall become effective only after there is a final decision of the Secretary pursuant to § 1003.125(f), or at any earlier date that the respondent fails, within the time permitted, to exercise his or her right to a hearing under § 1003.109 or administrative review under § 1003.125. The effect of such suspension shall be governed by 42 CFR § 1001.126.

(c) When the Inspector General proposes to suspend a long-term care facility from the Medicare and Medicaid programs, he or she shall, at the same time he or she notifies the respondent, notify the appropriate State Office of Aging, the long-term care ombudsman, and the State Medicaid agency of the Inspector General's intention to suspend the facility.

§ 1003.106 Determinations regarding the amount of the penalty and assessment.

(a) In determining the amount of any penalty or assessment, the Department shall take into account, in accordance with this section: (1) The nature of the claim or request for payment and the circumstances under which it was presented, (2) the degree of culpability of the person submitting the claim or request for payment, (3) the history of prior offenses of the person submitting the claim or request for payment, (4) the financial condition of the person presenting the claim or request for payment, and (5) such other matters as justice may require.

(b) *Guidelines for determining the amount of the penalty or assessment.* As guidelines for taking into account the factors listed in paragraph (a), of this section, the following circumstances are to be considered:

(1) *Nature and circumstances of the claim.* It should be considered a mitigating circumstance if all the items or services subject to a determination under § 1003.102 included in the action brought under this part were of the same type and occurred within a short period of time, there were few such items or services, and the total amount claimed for such items or services was less than $1,000. It should be considered an aggravating circumstance if such items or services were of several types, occurred over a lengthy period of time, there were many such items or services (or the nature and circumstances indicate a pattern of claims for such items or services), or the amount claimed for such items or services was substantial.

(2) *Degree of culpability.* It should be considered a mitigating circumstance if the claim for the item or service was the result of an unintentional and unrecognized error in the process respondent followed in presenting claims, and corrective steps were taken promptly after the error was discovered. It should be considered an aggravating circumstance if the respondent knew the item or service was not provided as claimed, or if the respondent knew that no payment could be made because he had been excluded from program reimbursement as specified in § 1003.102(a)(2) or because payment would violate the terms of an assignment agreement or an agreement with a State agency under § 1003.102(b).

(3) *Prior offenses.* It should be considered an aggravating circumstance if at any time prior to the presentation of any claim which included an item or service subject to a determination under § 1003.102, the respondent was held liable for criminal, civil, or administrative sanctions in connection with a program covered by this part or any other public or private program of reimbursement for medical services.

(4) *Financial condition.* It should be considered a mitigating circumstance if imposition of the penalty or assessment without reduction will jeopardize the ability of the respondent to continue as a health care provider. In all cases, the resources available to the respondent

will be considered when determining the amount of the penalty and assessment.

(5) *Other matters as justice may require.* Other circumstances of an aggravating or mitigating nature should be taken into account if, in the interests of justice, they require either a reduction of the penalty or assessment or an increase in order to assure the achievement of the purposes of this part.

(c) As guidelines for determining the amount of the penalty and assessment to be imposed, for every item or service subject to a determination under § 1003.102:

(1) If there are substantial or several mitigating circumstances, the aggregate amount of the penalty and assessment should be set at an amount sufficiently below the maximum permitted by § 1003.103, to reflect that fact.

(2) If there are substantial or several aggravating circumstances, the aggregate amount of the penalty and assessment should be set at an amount sufficiently close to or at the maximum permitted by § 1003.103, to reflect that fact.

(3) Unless there are extraordinary mitigating circumstances, the aggregate amount of the penalty and assessment should never be less than double the approximate amount of damages sustained by the United States, or any State, as a result of claims subject to a determination under § 1003.102.

(d) The guidelines set forth in this section are not binding. Moreover, nothing in this section shall limit the authority of the Department to settle any issue or case as provided by § 1003.126, or to compromise any penalty and assessment as provided by § 1003.128.

§ 1003.107 Determinations regarding suspension.

In determining whether to suspend a person and the duration of a suspension, the Department will take into account the circumstances set forth in § 1003.106(a) and described in § 1003.106(b). Where there are aggravating circumstances as described in § 1003.106(b), the person should be suspended. The guidelines set forth in this section are not binding. Moreover, nothing in this section shall limit the authority of the Department to settle any issue or case as provided by § 1003.126 or to compromise any suspension as provided by § 1003.128.

§ 1003.108 Penalty not exclusive.

A penalty imposed under this part is in addition to any other penalties prescribed by law.

§ 1003.109 Notice of proposed determination.

(a) If the Inspector General proposes to impose a penalty and assessment, or to suspend a respondent from participation in Medicare or Medicaid, in accordance with this part, he or she must deliver or send by certified mail, return receipt requested, to the respondent, written notice of his or her intent to impose a penalty, assessment and suspension, as applicable. The notice will include reference to the statutory basis for the penalty, assessment, and suspension; description of the claims and requests for payment with respect to which the penalty, assessment, and suspension are proposed (except in cases where the Inspector General is relying upon statistical sampling pursuant to § 1003.113, in which case the notice shall describe those claims and requests for payment comprising the sample upon which the Inspector General is relying and shall also briefly describe the statistical sampling technique utilized by the Inspector General); the reason why such claims and requests for payment subject the respondent to a penalty, assessment, and suspension; the amount of the proposed penalty, assessment, and the period of proposed suspension (where applicable); any circumstances described in § 1003.106 which were considered when determining the amount of the proposed penalty and assessment and the period of suspension; instructions for responding to the notice, including a specific statement of respondent's right to a hearing, of the fact that failure to request a hearing within 30 days permits the imposition of the proposed penalty, assessment, and suspension without right to appeal, and of respondent's right to request an extension of time in which to respond to the notice and a copy of the rules contained in this part.

(b) Within 30 days of the date of receipt of the notice, the respondent may submit:

(1) A written statement accepting imposition of the penalty, assessment, and suspension as proposed; or

(2) A written request for a hearing which shall be accompanied by an answer to the notice that (i) with respect to the claims and requests for payment identified in the notice, admits or denies that the respondent presented or caused to be presented such claims and requests for payment, (ii) states any defense on which the respondent intends to rely, and (iii) may state any reasons which respondent contends should result in a reduction or modification of a penalty, assessment, and suspension.

(c) The Inspector General may extend the 30 day period for good cause shown by the respondent upon request made prior to the expiration of the 30 day period.

§ 1003.110 Failure to request a hearing.

If the respondent does not request a hearing within the time prescribed by § 1003.109 (b) and (c), the Inspector General may impose the proposed penalty, assessment, and suspension, or any less severe penalty, assessment, and suspension. The Inspector General shall notify the respondent by certified mail, return receipt requested, of any penalty, assessment, and suspension that has been imposed and of the means by which the respondent may satisfy the judgment. The respondent has no right to appeal a penalty, assessment, and suspension, with respect to which he or she has not requested a hearing.

§ 1003.111 Initiation of hearing.

If the respondent requests a hearing in accordance with § 1003.109(b)(2), determination of the penalty, assessment, and suspension will be assigned to an ALJ for hearing.

§ 1003.112 Parties.

The Inspector General and the respondent are parties to the hearing.

§ 1003.113 Notice of hearing.

The ALJ will send written notice to the respondent and to the Inspector General stating the time and place for the hearing and the issues that will be considered. In fixing the time and place of the hearing, the ALJ will attempt to minimize the costs to the parties.

§ 1003.114 Issues and burden of proof.

(a) To the extent that a proposed penalty and assessment is based on claims or requests for payment presented on or after August 13, 1981, the Inspector General must prove by a preponderance of the evidence that the respondent presented or caused to be presented such claims or requests for payment as described in § 1003.102.

(b) To the extent that a proposed penalty and assessment is based on claims presented before August 13, 1981, the Inspector General must prove by clear and convincing evidence that:

(1) The respondent presented or caused to be presented such claims as described in § 1003.102; and

(2) Presenting or causing to be presented such claims could have rendered respondent liable under the provisions of the False Claims Act, 31 U.S.C. 3729 *et seq.*, for payment of an amount not less than that proposed.

(c) Where a final determination that the respondent presented or caused to be presented a claim or request for payment falling within the scope of § 1003.102 has been rendered in any proceeding in which the respondent was a party and had an opportunity to be heard, the respondent shall be bound by such determination in any proceeding under this part.

(d) The respondent shall bear the burden of producing and proving by a preponderance of the evidence any circumstances described in § 1003.106 that would justify reducing the amount of the penalty or assessment, or the period of suspension.

§ 1003.115 Authority of ALJ.

(a) The ALJ will conduct a fair hearing, avoid delay, maintain order, and assure that a record of the proceeding is made.

(b) The ALJ shall have the authority to:

(1) Change the date, time, and place of the hearing, upon notice to the parties;

(2) Continue or recess the hearing in whole or in part for a reasonable period of time;

(3) Hold conferences to identify or simplify the issues, or to consider other matters that may aid in the expeditious disposition of the proceeding;

(4) Administer oaths and affirmations;

(5) Issue subpoenas in hearings involving Medicare claims;

(6) Rule on motions and other procedural matters;

(7) Regulate the course of the hearing and the conduct of counsel;

(8) Examine witnesses;

(9) Receive, rule on, exclude, or limit evidence;

(10) Upon motion of a party, decide cases, in whole or in part, by summary judgment where there is no disputed issue of material fact;

(11) Issue a written opinion containing findings of fact, conclusions of law, and an initial decision on whether a penalty or assessment or suspension should be imposed, and if so, the amount.

(c) The ALJ does not have the authority to decide upon the validity of Federal statutes or regulations.

(d) (1) The ALJ shall schedule a prehearing conference at a reasonable time in advance of the hearing, at which the parties or their counsel shall meet with the ALJ to consider:

(i) Simplification of the issues;

(ii) The necessity or desirability of amendments to pleadings for purposes of clarification, simplification, or limitation;

(iii) Stipulations, admissions of fact or the contents and authenticity of documents;

(iv) Limitation of the number of witnesses;

(v) Scheduling dates for the exchange of witness lists and of proposed exhibits; and

(vi) Such other matters as may tend to expedite the disposition of the proceedings.

(2) The ALJ shall issue an order containing all matters described in paragraph (d)(1) of this section agreed upon by the parties or ordered by the ALJ.

§ 1003.116 Rights of parties.

(a) All parties may:

(1) Appear by counsel (or, in the case of a government agency, other authorized representative) in all a hearing proceedings.

(2) Participate in any prehearing or posthearing conference held by the ALJ.

(3) Agree to stipulations as to facts which will be made part of the record.

(4) Make opening statements at the hearing.

(5) Present material evidence which is relevant to the issues at the hearing.

(6) Present witnesses who then must be available for cross-examination by all other parties.

(7) Present oral arguments at the hearing.

(8) Submit written briefs, proposed findings of fact, and proposed conclusions of law, after the hearing.

(b)(1) A party wishing to procure the appearance and testimony at the hearing of any person having personal knowledge of the matters in issue may serve on the person a notice to appear as witness. The notice shall set forth the time, date, and place at which the person is to appear for the purpose of giving testimony and the categories of documents the witness is to bring to the hearing, if any. A copy of the notice shall be filed with the ALJ and additional copies shall be served upon all parties.

(i) In all hearings, it shall be the obligation of each party to produce for examination any person, along with such documents as may be requested, at the time and place, and on the date set forth in a notice to appear as witness, if that party has control over such person.

(ii) In hearings involving Medicare claims, a notice to appear as witness may be accompanied by an administrative subpoena. A party who desires the issuance of a subpoena shall, not less than 15 days prior to the time fixed for a hearing, file with the ALJ a written request therefor, designating the witness(es) or document(s) to be produced and describing the address and location thereof with sufficient particularity to permit such witness(es) or document(s) to be found. A subpoena issued under this section shall be in the name of the Secretary. The party requesting the subpoena shall pay the cost of service and the fees and the mileage of any witnesses so subpoenaed, as provided in 28 U.S.C. 1821. Subpoenas shall be served by the party requesting issuance in the manner provided in section 205(d) of the Act. A check for witness fees and mileage shall accompany the subpoena when served.

(3) A party or prospective witness may file an objection to notice to appear as witness or, in the case of a subpoena a motion to quash within five days after the notice or subpoena is served, stating with particularity the reasons why the party should not be required to produce a requested witness or why the prospective witness should not be required to appear. Where the party serving the notice has reason to believe that the party being served is likely to refuse to produce the requested witness, that party may move for an order enforcing the notice to appear as witness. Upon the failure of any person to comply with a subpoena issued under this section, the Secretary shall institute enforcement proceedings before the appropriate district court pursuant to section 205(e) of the Act, unless in the judgment of the Secretary the enforcement of such subpoena would be inconsistent with law or the purposes of the Act.

§ 1003.117 Discovery.

(a) Upon request of a party, the ALJ shall allow that party to inspect and copy all documents, unless privileged, relevant to the issues in the proceeding that are in the possession or control of the other party. Depositions, interrogatories, and other forms of discovery are not authorized except as provided for in paragraph (b) of this section. Nothing in this section shall be construed as requiring the disclosure of internal government documents prepared in conjunction with the investigation or litigation of the case.

(b) In those cases in which the Inspector General intends to introduce the results of a statistical sampling study as evidence at the hearing pursuant to § 1003.133, the Inspector General, upon request of the respondent, shall make available for deposition, the individual(s) responsible for conducting the statistical sampling study. Should respondent intend to introduce expert testimony to rebut the statistical sampling study at the hearing, the respondent shall, upon request of the Inspector General, make available for deposition the expert witness or

witnesses who will be called to so testify at the hearing. Such depositions shall be conducted in accordance with Rules 28 and 30 of the Federal Rules of Civil Procedure. Such depositions may be used by an adverse party for any purpose at the hearing. The failure of a party to make witnesses available for deposition pursuant to this section shall serve to bar the introduction of testimony or other evidence from those witnesses at the hearing.

(c)(1) Witness lists, prior statements of witnesses, and hearing exhibits shall be exchanged at least 15 days in advance of the hearing, or such other later time as is set by the ALJ. Each party shall provide to the other party copies of all exhibits that it then plans to use at the hearing.

(2) All discovery shall be concluded at least 30 days prior to the hearing or by such other later time as ordered by the ALJ. The ALJ shall, however, allow adequate time for discovery.

§ 1003.118 Evidence and witnesses.

(a) Testimony at the hearing is given orally and under oath or affirmation. Written direct testimony may be used in the discretion of the ALJ. Witnesses must be available at the hearing for cross-examination by all parties.

(b) The parties may agree to stipulations of fact. Such stipulations, or any exhibit proposed by a party, must be exchanged at a prehearing conference or otherwise prior to the hearing, if the ALJ so decides.

(c) Technical rules of evidence are not applicable to the hearing, except that when reasonably necessary, the ALJ must apply rules or principles designed to assure production of the most credible evidence available and to subject testimony to test by cross-examination.

(d) A witness may be cross-examined on any matter relevant to the proceeding without regard to the scope of his or her direct examination.

(e) The ALJ shall exclude irrelevant, immaterial, or unduly repetitious evidence.

(f) All documents and other evidence offered or taken for the record shall be open to examination by the parties.

§ 1003.119 Exclusion from the hearing for misconduct.

Disrespectful or disorderly language or conduct, refusal to comply with directions, or continued use of dilatory tactics by any individual at the hearing constitutes grounds for immediate exclusion of that individual from the hearing by the ALJ.

§ 1003.120 Ex parte contacts.

(a) Except for matters related to the issuance of ex parte subpoenas, the ALJ may not consult or be consulted by a party or any other individual (except employees of his or her own office) on any matter in issue, unless on notice and opportunity for all parties to participate.

(b) The ALJ shall not consider letters or other contacts from non-parties expressing views or urging action.

§ 1003.121 Separation of functions.

An employee or an agent of the Department, who is engaged in the performance of investigative or prosecutive functions for or on behalf of the Department in a case may not, in that or a factually related case, participate or advise in the decision, except as witness or counsel in public proceedings.

§ 1003.122 Official transcript.

The hearing will be recorded and transcribed. Transcripts may be obtained from the reporter by a party or the public at not to exceed the maximum rates fixed by contract between the Department and the reporter.

§ 1003.123 Post-hearing briefs.

The ALJ shall fix the time for filing post-hearing briefs, which shall not exceed 30 days from the date of receipt of the hearing transcript by the parties. Upon motion by a party, the ALJ may extend the time in which to file post-hearing briefs for a period of up to 60 days where the hearing was of unusual length or complexity or for other good cause shown. Such briefs may contain proposed findings of fact and conclusions of law. The ALJ may permit the parties to file reply briefs.

§ 1003.124 Record for decision.

The transcript of testimony, exhibits, and all papers, requests and rulings filed or made in the proceedings, constitute the exclusive record for the ALJ's initial decision.

§ 1003.125 Initial decision; administrative review; finality.

(a) The ALJ shall serve the initial decision on all parties within 60 days after the time for submission of post-hearing briefs and reply briefs (if permitted) has expired.

(b) The initial decision shall contain findings of fact, conclusions of law, and the amount of any penalties and assessments (which may be the amount proposed by the Inspector General, or a greater or lesser amount), and the length of any suspension (which may be for the period proposed by the Inspector General, or a greater or lesser peirod of time), imposed upon the respondent thereby.

(c) The findings of fact shall include a finding on each of the following issues for every item or service with respect to which a penalty or assessment was proposed.

(1) Whether the item or service is subject to a determination under § 1003.102;

(2) If the item or service is subject to a determination under § 1003.102 whether there are mitigating or aggravating circumstances as described in § 1003.106(b).

(d) The initial decision of the ALJ becomes final and binding on the parties 30 days after notice thereof is received by the respondent, unless on or before that 30th day a party files with the ALJ written exception to the initial decision and supporting reasons for the exceptions.

(e) A party opposing exceptions may file a brief in opposition to exceptions within 30 days after receipt of the exceptions or may file a brief which is limited to the issue of whether or not the Secretary should review the initial decision of the ALJ.

(f)(1) If a party timely files exceptions under paragraph (d) of this section, the ALJ will forward to the Secretary the record of the proceeding, the exceptions and reasons therefor, and any briefs filed in opposition.

(2) After the Secretary receives the initial decision, the record on which it is based, and submissions of the parties made subsequent to the decision, the Secretary will determine whether he or she will review the initial decision of the ALJ.

(3) In any case in which the Secretary decides to review the initial decision of the ALJ, he or she will inform each party of this decision by written notice. A party opposing exceptions may file a brief addressing any relevant issues not addressed in any brief filed under paragraph (e) of this section within 30 days after receipt of the Secretary's written notice under this paragraph. After the Secretary has reviewed the initial decision, the record on which it is based, and submissions of the parties made subsequent to the decision, the Secretary will affirm, modify, or reverse the initial decision, or remand the case to an ALJ. The Secretary may modify the penalty, assessment, or suspension, to be more or less severe than that imposed by the ALJ. There is no right to appear personally before the Secretary. A copy of the decision of the Secretary will be sent to the respondent by certified mail, mailed return receipt requested, and served upon the

Inspector General. Except in the case of a remand, the decision of the Secretary becomes final and binding on the parties 60 days after notice thereof is received by the respondent.

(4) In any case in which the Secretary declines to review the initial decision of the ALJ, he or she will notify the respondent by certified mail, return receipt requested, and inform the Inspector General of this decision. The initial decision of the ALJ becomes final and binding on the parties 60 days after the Secretary's notice is received by the respondent.

(5)(i) The respondent may file with the ALJ a request for stay of the effective date of the final decision pending appeal. Such request shall state the grounds upon which respondent relies in requesting the stay, together with a copy of the notice(s) of appeal filed by respondent seeking review of the decision of the Secretary. The filing of such a request shall automatically act to stay the effective date of the decision of the Secretary until such time as the ALJ rules upon the request.

(ii) The Inspector General may file an opposition to respondent's request for a stay within 10 days of receipt of the request. If the Inspector General fails to file such an opposition within the allotted time, or indicates that he or she has no objection to the request, the ALJ shall grant the stay without requiring respondent to give a bond or other security.

(iii) In those cases in which the Inspector General opposes respondent's request for a stay, the ALJ may grant respondent's request where justice so requires and to the extent necessary to prevent irreparable harm. An ALJ may grant an opposed request to stay a final decision requiring the payment of money only upon the respondent's giving of a bond or other adequate security. The ALJ shall rule upon an opposed request for stay within 10 days of the receipt of the opposition of the Inspector General. A decision of the ALJ denying respondent's request for a stay shall constitute final agency action.

§ 1003.126 Settlement.

The Inspector General has exclusive authority to settle any issues or case, without the consent of the ALJ or the Secretary, at any time prior to a final decision by the Secretary. Thereafter, the General Counsel has such exclusive authority.

§ 1003.127 Judicial review.

(a) Section 1128A(d) of the Act authorizes judicial review of a penalty or assessment imposed under § 1003.110 or § 1003.125 that has become final. Judicial review may be sought by a respondent only with respect to a penalty or assessment with respect to which the respondent filed an exception under § 1003.125(d) unless the failure or neglect to urge such exception shall be excused by the court pursuant to section 1128A(d) because of extraordinary circumstances.

(b) Section 1128(d) of the Act authorizes judicial review of a determination to bar a person from participation in Medicare or Medicaid pursuant to section 1128(b) of the Act. Judicial review may be sought by a respondent only with respect to a suspension with respect to which the respondent filed an exception under § 1003.125(d) unless the failure or neglect to urge such exception shall be excused because of extraordinary circumstances.

§ 1003.128 Collection of penalty and assessment.

(a) Once a determination by the Secretary has become final under § 1003.125(f), collection of any penalty and assessment shall be the responsibility of HCFA, except in the case of the Maternal and Child Health Services Block Grant, where the collection shall be the responsibility of the Public Health Service.

(b) A penalty and assessment imposed under this part may be compromised by the General Counsel, after consultation with the Inspector General, and may be recovered in a civil action brought in the United States district court for the district where the claim was presented, or where the respondent resides.

(c) The amount of a penalty and assessment when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States, or by a State agency, to the respondent.

(d) Matters that were raised or that could have been raised in a hearing before an ALJ or in an appeal under section 1128A(d) of the Act may not be raised as a defense in a civil action by the United States to collect a penalty under this part.

§ 1003.129 Notice to other agencies.

Whenever a penalty and assessment or suspension imposed under this part becomes final, the following organizations and entities will be notified—the appropriate State or local medical or professional association, the appropriate Peer Review Organization, the State Medicaid agency, the appropriate Medicare carrier or intermediary, the appropriate State or local licensing agency or organization (including the Medicare and Medicaid State survey agencies), the long-term care ombudsman, and where appropriate, the State agency administering a Maternal and Child Health Services Block Grant Program, that the penalty and assessment or suspension have become final and the reasons for them. In cases involving suspensions, notice will also be given to the public of the suspension and its effective date. HCFA will also provide to the State Medicaid agency will also receive the notice required under section 1128(b) of the Social Security Act.

§ 1003.130 Form, filing and service of papers; computation of time; motions, disposition of motions.

(a) *Form, filing and service of papers*—(1) *Form.* The original and one copy of all papers in a proceeding conducted under this part shall be filed with the ALJ assigned to the case or with the Chief ALJ if the case has not been assigned. Every pleading and paper filed in the proceeding shall contain a caption setting forth the title of the action, the case file number assigned by the ALJ, and a designation of the paper (e.g., motion for summary judgment). The paper shall be signed and shall contain the address and telephone number of the person representing the party or the person on whose behalf the paper was filed. Unless the ALJ otherwise orders with respect to specific papers in a specific case, all such papers are public documents. Papers are considered filed when they are received by the ALJ.

(2) *Service.* Service upon any party shall be made by the party filing the document by delivering or mailing a copy to the party's last known address. When a party is represented by an attorney, service shall be made upon the attorney.

(3) *Proof of service.* A certificate of the person serving the document by personal delivery or by mailing, setting forth the manner of service, shall be proof of service.

(b) *Computation of time.* In computing any period of time under these rules or in an order issued hereunder, the time begins with the day following the act, event, or default, and includes the last day of the period, unless it is a Saturday, Sunday, or legal holiday observed by the Federal government, in which event it includes the next business day. When the period of time allowed is less than seven days, intermediate Saturdays, Sundays, and legal holidays observed by the Federal government shall be excluded from the computation.

(c) *Motions, disposition of motions*—(1) *Motions.* Motions shall state the relief sought, the authority relied upon and the facts alleged, and shall be filed with the ALJ. If made before or after the hearing itself, the motions shall be in writing. If made at the hearing, motions may be stated orally; but the ALJ may require that they be reduced to writing and filed and served on all parties in the same manner as a formal motion. Unless otherwise ordered by the ALJ, written motions shall be accompanied by a supporting memorandum. Within 10 days after a written motion is served, or such other time period as may be fixed by ALJ, any party may file a response to a motion.

(2) *Disposition of motions.* The ALJ may not grant a written motion prior to expiration of the time for filing responses thereto, except upon consent of the parties or following a hearing, but may overrule or deny such motion without awaiting response. The ALJ shall make every reasonable effort to dispose of all outstanding motions prior to the beginning of the hearing.

§ 1003.131 Records to be public.

All documents contained in the records of formal proceedings for imposing a penalty and assessment or suspension under this part may be inspected and copied, unless ordered sealed by the ALJ.

§ 1003.132 Limitations.

No action under this part shall be entertained unless commenced, pursuant to § 1003.109(a) of this part, within five years from the date on which the right of action accrued.

§ 1003.133 Statistical sampling.

(a) In meeting the burden of proof set forth in § 1003.114, the Inspector General may introduce the results of a statistical sampling study as evidence of the number and amount of claims and/or requests for payment as described in § 1003.102 that were presented or caused to be presented by respondent. Such a statistical sampling study, if based upon an appropriate sampling and computed by valid statistical methods, shall constitute prima facie evidence of the number and amount of claims or requests for payment as described in § 1003.102.

(b) Once the Inspector General has made a prima facie case as described in paragraph (a) of this section, the burden of production shall shift to respondent to produce evidence reasonably calculated to rebut the findings of the statistical sampling study. The Inspector General will then be given the opportunity to rebut this evidence.

Part 1004—IMPOSITION OF SANCTIONS ON HEALTH CARE PRACTITIONERS AND PROVIDERS OF HEALTH CARE SERVICES BY A PEER REVIEW ORGANIZATION

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1004.1 Scope and definitions.

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Subpart F—Appeals

1004.130 Appeal rights.

Authority: Secs. 1102 and 1156 of the Social Security Act (42 U.S.C. 1302 and 1320c–5).

Subpart A—General Provisions

§ 1004.1 Scope and definitions.

(a) *Scope.*

This part implements section 1156 of the Act (PROs) by—

(1) Setting forth certain obligations imposed on practitioners and providers of services under Medicare;

(2) Establishing criteria and procedures for the reports required from PSROs and PROs when there is failure to meet those obligations;

(3) Specifying the policies and procedures for making determinations on violations and imposing sanctions; and

(4) Defining the procedures for appeals by the affected party and the procedures for reinstatements.

(b) *Definitions.* As used in this part, unless the context indicates otherwise:

"Economically" means that services are provided at the least expensive, medically appropriate type of setting or level of care available.

"Exclusion" means that items or services furnished or ordered by a specified health care practitioner, provider, or other person during a specified period are not reimbursed under Medicare.

"Gross and flagrant violation" means a violation of an obligation has occurred in one or more instances which presents an imminent danger to the health, safety or well-being of a Medicare beneficiary or places the beneficiary unnecessarily in high-risk situations.

"Health care services" or "Services" means services or items for which payment may be made (in whole or in part) under the Medicare program.

"Obligation" means any of the obligations specified at section 1156(a) of the Act.

"OIG" stands for the Office of the Inspector General, Department of Health and Human Services.

"Other person" means a hospital or other health care facility, an organization, or an agency that furnishes health care services for which payment may be made under the Medicare program.

"Physician" means a doctor of medicine or osteopathy or another individual who is authorized under State or Federal law to practice medicine and surgery or osteopathy.

"Practitioner" means a physician or other health care professional licensed under State law to practice his or her profession.

"PRO area" means the geographic area subject to review by a particular PRO.

"Provider" means a hospital or other health care facility, agency, or organization.

"Sanction" means an exclusion or monetary penalty that the Secretary may impose on a practitioner or other person as a result of a recommendation from a PRO.

"Substantial violation in a substantial number of cases" means a pattern of care has been provided that is inappropriate, unnecessary, or does not meet recognized professional standards of care, or is not supported by the necessary documentation of care as required by the PRO.

Subpart B—Sections Under the PRO Program; General Provisions

§ 1004.10 Statutory obligations of practitioners and other persons.

It is the obligation of any health care practitioner or other person who furnishes or orders health care services that may be reimbursed under Medicare, to ensure, to the extent of his or her authority, that those services are—

(a) Furnished economically and only when and to the extent medically necessary;

(b) Of a quality that meets professionally recognized standards of health care; and

(c) Supported by evidence of the medical necessity and quality of the services in the form and fashion that the reviewing PRO may reasonably require (including copies of the necessary documentation and evidence of compliance with pre-admission or pre-procedure review requirements to ensure that the practitioner or other person is meeting the obligations imposed by section 1156(a) of the Act.

§ 1004.20 Sanctions.

In addition to any other sanction provided under law, a practitioner or other person may be—

(a) Excluded from Medicare; or

(b) In lieu of exclusion and as a condition for continued participation in Medicare, if the violation involved the provision or ordering of health care services that were medically improper or unnecessary, required to pay an amount not in excess of the cost of the improper or unnecessary services that were furnished or ordered. The practitioner or other person will be required either to pay the monetary assessment within 6 months of the date of notice or have it deducted from any sums the Federal Government owes the practitioner or other person.

Subpart C—PRO Responsibilities

§ 1004.30 Basic responsibilities.

(a) The PRO must use its authority or influence to enlist the support of other professional or government agencies to ensure that each practitioner or other person complies with the obligations specified in § 1004.10.

(b) The PRO must identify situations where the obligations specified in § 1004.10 are violated and afford the practitioner or other person reasonable notice and opportunity for discussion in accordance with §§ 1004.40 and 1004.50.

(c) The PRO must submit a report to the OIG after the notice and opportunity provided under paragraph (b) of this section, if the PRO determines that the practitioner or other person has—

(1) Failed substantially to comply with any obligation in a substantial number of cases; or

(2) Grossly and flagrantly violated any obligation in one or more instances.

(d) The PRO report to the OIG must comply with the provisions of § 1004.70.

(e) The PRO must deny services or items ordered by an excluded practitioner or other person when the PRO identifies the services or items and reports the findings to HCFA.

§ 1004.40 Action on identification of a violation.

When a PRO identifies a violation, it must determine the nature of the violation.

(a) If the PRO determines the violation as one that is gross and flagrant, it must proceed in accordance with § 1004.50.

(b) If the PRO determines the violation as a substantial violation in a substantial number of cases it must send the practitioner or other person a written initial notice of the identification of a violation containing the following information:

(1) The obligation involved.

(2) The situation, circumstances, or activity that resulted in a violation.

(3) The authority and responsibility of the PRO to report violations of obligations.

(4) At the discretion of the PRO, a suggested method for correcting the situation and a time period for corrective action.

(5) The sanction that the PRO could recommend to the OIG if the violation continues.

(6) An invitation to submit additional information to or discuss the problem with representatives of the PRO within 20 days of receipt of the notice. The date of receipt is presumed to be five days after the date on the notice, unless there is a reasonable showing to the contrary.

(7) A summary of the information used by the PRO in arriving at its determination of a violation of an obligation.

(Approved by the Office of Management and Budget under control number 0938–0444)

§ 1004.50 Action on determination of a violation.

(a) *Written notice.* The PRO must give written notice to the practitioner or other person if it determines that—

(1) A substantial violation has occurred in a substantial number of cases; or

(2) A violation is gross and flagrant in one or more cases.

(b) *Contents.* The notice must contain the following information:

(1) The determination of a violation.

(2) The obligation violated.

(3) The basis for the determination.

(4) The sanction the PRO will recommend to the OIG.

(5) The right of the practitioner or other person to submit to the PRO within 30 days of receipt of the notice, additional information or a written request for a meeting with the PRO to review and discuss the determination, or both. The date of receipt is presumed to be five days after the date on the notice, unless there is a reasonable showing to the contrary.

(6) A copy of the material used by the PRO in arriving at its determination.

(c) *Review of PRO determination.*

(1) The PRO may, on the basis of additional information received, affirm, modify, or reverse its determination.

(2) The PRO must give written notice to the practitioner or other person, of any action it takes as a result of the additional information received, as specified in § 1004.60

(Approved by the Office of Management and Budget under control number 0938–0444)

§ 1004.60 Final PRO determination of a violation.

If the issue is not resolved to the PRO's satisfaction as specified in § 1004.50(c), the PRO must—

(a) Submit its report and recommendation to the OIG; and

(b) Send the affected practitioner or other person a concurrent final notice, with a copy of the PRO report that is being forwarded to the OIG, advising that—

(1) The PRO recommendation has been submitted to the OIG;

(2) The practitioner or other person has 30 days from receipt of this final notice to submit any additional written material or documentary evidence to the OIG at its central office location. The date of receipt is presumed to be five days after the date on the notice, unless there is a reasonable showing to the contrary; and

(3) Due to the 120-day statutory requirement specified at § 1004.90(e), the period for submitting additional information will not be extended and any material received by the OIG after the 30-day period will not be considered.

(Approved by the Office of Management and Budget under control number 0938–0444)

§ 1004.70 PRO report to OIG.

(a) *Manner of reporting.* If the PRO determines that a substantial violation has occurred in a substantial number of cases or that a gross and flagrant violation has occurred, it must submit a report and recommendation to the OIG at the regional office with jurisdiction.

(b) *Content of report,* The PRO report must include the following information—

(1) Identification of the practitioner or other persons and when applicable, the name of the director, administrator, or owner of the entity involved;

(2) The type of health care services involved;

(3) A description of each failure to comply with an obligation, including

specific dates, places, circumstances, and any other relevant facts;

(4) Pertinent documentary evidence;

(5) Copies of written correspondence and written summaries of oral exchanges with the practitioner or other person regarding the violation;

(6) Th PRO's determination that an obligation under section 1156(a) of the Act has been violated and that the violation is substantial and has occurred in a substantial number of cases or is gross and flagrant;

(7) The professional qualifications of the PRO's reviewers' and

(8) The PRO's sanction recommendation.

(c) *PRO Recommendation.* The PRO must specify in its report—

(1) The sanction recommended;

(2) The amount of the monetary penalty recommended, if applicable;

(3) The period of exclusion recommended, if applicable; and

(4) A recommendation as to whether the practitioner or other person is unable or unwilling substantially to comply with the obligation that was violated.

(Approved by the Office of Management and Budget under control number 0938–0444)

§ 1004.80 Basis for recommended sanction.

The PRO's specific recommendation must be based on a consideration of—

(a) The type of offense involved:

(b) The severity of the offense;

(c) The deterrent value;

(d) The practitioner's or other person's previous sanction record;

(e) The availability of alternative sources of services in the community; and

(f) Any other factors that the PRO considers relevant (for example, the duration of the problem).

Subpart D—OIG Responsibilities

§ 1004.90 Acknowledgement and review of report.

(a) *Acknowledgement.* The OIG will inform the PRO of the date it received the PRO's report and recommendation.

(b) *Review.* The OIG will review the PRO report and recommendation to determine whether—

(1) The PRO is following its procedures;

(2) A violation has occurred; and

(3) The practitioner or other person has demonstrated an unwillingness or lack of ability substantially to comply with an obligation.

(c) *Rejection of the PRO recommendation.* If the OIG decides that a sanction is not warranted, it will notify the PRO that recommended the sanction and the affected practitioner or other person that the recommendation is rejected.

(d) *Decision of sanction.* If the OIG decides that a violation of obligations has occurred, it will determine the appropriate sanction by considering—

(1) The recommendation of the PRO;

(2) The type of offense;

(3) The severity of the offense;

(4) The previous sanction record of the practitioner or other person;

(5) The availability of alternative sources of services in the community;

(6) Any prior problems the Medicare carrier or intermediary has had with the practitioner or other person;

(7) Whether the practitioner or other person is unable or unwilling to comply substantially with the obligations; and

(8) Any other matters relevant to the particular case.

(e) *exclusion sanction.* If the PRO submits a recommendation for exclusion to the OIG, and a determination is not made by the 120th day after actual receipt by the OIG, the exclusion sanction recommended will become effective and the OIG will provide notice in accordance with § 1004.100(f).

(f) *Monetary penalty.* If the PRO recommendation is to assess a monetary penalty, the 120-day provision does not apply and the OIG will provide notice in accordance with § 1004.100 (a) through (e).

§ 1004.100 Notice of sanction.

(a) The OIG notifies the practitioner or other person of the adverse determination and of the sanction to be imposed.

(b) The sanction is effective 15 days from the date of receipt of the notice. The date of receipt is presumed to be 5 days after the date on the notice, unless there is a reasonable showing to the contrary.

(c) The notice specifies—

(1) The legal and factual basis for the determination;

(2) The sanction to be imposed;

(3) The effective date and, if appropriate, the duration of the exclusion;

(4) The appeal rights of the practitioner or other person; and

(5) In the case of exclusion, the earliest date on which the OIG will accept a request for reinstatement.

(d) The OIG notifies the public by publishing in a newspaper of general circulation in the PRO area a notice that identifies the sanctioned practitioner or other person, the obligation that has been violated, the sanction imposed and, if the sanction is exclusion, the effective date and duration.

(e) Notice of the sanction is also provided to the following entities as appropriate:

(1) The PRO that originated the sanction report.

(2) PROs in adjacent areas.

(3) State Medicaid fraud control units and State licensing bodies.

(4) Appropriate Medicare contractors and State agencies.

(5) Hospitals, including the hospital where the sanctioned individual's case originated and where the individual currently has privileges, if known; skilled nursing facilities, home health agencies, and health maintenance organizations (HMOs).

(6) Medical societies and other professional organizations.

(7) Medical carriers and intermediaries, health care prepayment plans, and other affected agencies and organizations.

(f) If an exclusion sanction is effected because a decision was not made within 120 days after receipt of the PRO recommendation, notification is as follows:

(1) The OIG notifies the practitioner or other person that the exclusion from the Medicare program is effective 15 days from the date the notice is received by the practitioner or other person. The date of receipt is presumed to be five days after the date on the notice, unless there is a reasonable showing to the contrary.

(2) Notice of the sanction is also provided as specified in paragraph (e) of this section.

(3) As soon as possible after the 120th day, the OIG will issue a notice to the practitioner or other person affirming the PRO recommendation or modifying the recommendation based on the OIG's review of the case.

(g) The determination and notice of sanction provided for in this section constitute an "initial determination" and a "notice of initial determination" for purposes of the administrative appeals procedures specified in Subpart O of Part 405 of this title concerning determinations and appeals procedures for providers and suppliers.

Subpart E—Effect and Duration of Exclusion

§ 1004.110 Effect of an exclusion on Medicare payments and services.

(a) *General provisions.* Except as provided under paragraphs (b) and (c) of this section—

(1) Payment will not be made under Medicare to an excluded practitioner or other person for services or items

furnished or ordered during the period of exclusion;

(2) Payment will not be made under Medicare to any provider for services or items ordered by an excluded practitioner or other person when the order was a necessary precondition for payment under Medicare; and

(3) Assignment of a beneficiary's claim for services or items furnished or ordered by an excluded practitioner or other person on or after the effective date of exclusion will not be valid.

(b) *Exceptions.* Payment is available for services or items provided up to 30 days after the effective date of an exclusion for—

(1) Inpatient hospital or skilled nursing services or items furnished to a beneficiary who was admitted before the effective date of the exclusion; and

(2) Home health services or items furnished under a plan established before the effective date of the exclusion.

(c) *Denial of payments to beneficiaries.* If a beneficiary submits claims for services or items furnished or ordered by an excluded practitioner or other person on or after the effective date of exclusion—

(1) HCFA pays the first claim submitted and immediately gives the beneficiary notice of the exclusion; and

(2) The beneficiary's right to payment extends to services or items furnished or ordered up to 15 days after the date on the notice.

(d) *Effective date of termination of provider agreement.* The effective date of termination of a Medicare provider agreement is determined in accordance with §§ 1001.201 and 1001.211 of this chapter.

§ 1004.120 Reinstatement after exclusion.

Exclusion will remain in effect until—

(a) The OIG determines, in accordance with §§ 1001.130 through 1001.136 of this chapter, that the basis for the exclusion no longer exists and there is reasonable assurance that the problems will not recur, or

(b) The OIG's determination to exclude is reversed by a hearing decision.

§ 1004.130 Appeal rights.

(a) *Right to administrative review.*

(1) A practitioner or other person dissatisfied with an OIG determination or an exclusion that results from a determination not being made within 120 days is entitled to a hearing before an Administrative Law Judge and may also request a review of that decision by the Appeals Council in accordance with §§ 405.1530 through 405.1595 of this title.

(2) Due to the 120-day statutory requirement specified at § 1004.90(e) of this part, the following limitations apply:

(i) The period for submitting additional information will not be extended.

(ii) Any material received by the OIG after the 30-day period allowed, will not be considered and will not be subject to review by the Administrative Law Judge and the Appeals Council.

(3) The OIG's determination continues in effect unless reversed by a hearing decision.

(b) *Right to judicial review.* Any practitioner or other person dissatisfied with a decision of the Appeals Council or an administrative law judge (if a request for Appeals Council review is denied) may file a civil action in accordance with the provisions of section 205(g) of the Act.

TITLE 45—[AMENDED]

PART 101—[REMOVED]

II. In Title 45 of the Code of Federal Regulations, Part 101 is removed.

(Catalog of Federal Domestic Assistance Programs, No. 13.714, Medical Assistance Program; No. 13.773, Medicare—Hospital Insurance Program; and No. 13.744, Medicare—Supplementary Medical Insurance Program)

Dated: August 28, 1986.

R.P. Kusserow,

Inspector General, Department of Health and Human Services.

Approved: September 15, 1986.

Otis R. Bowen,

Secretary.

[FR Doc. 86-21751 Filed 9-29-86; 8:45 am]

BILLING CODE 4150-04-M

Health Care Financing Administration

42 CFR Parts 412, 420, 455, 466, 474 and 489

[BPO-061-F]

Medicare and Medicaid Programs; Program Integrity

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: This document removes rules pertaining to responsibilities delegated to the Department's Office of the Inspector General (OIG) and conforms other rules accordingly. Most of the content removed from HCFA rules is being included in a new Chapter V of this title—Office of the Inspector General—Health Care—Department of Health and Human Services. The new Chapter V is published elsewhere in this issue of the **Federal Register.**

EFFECTIVE DATE: These amendments are effective September 30, 1986.

FOR FURTHER INFORMATION CONTACT: Luisa V. Iglesias, (201) 245-0383.

SUPPLEMENTARY INFORMATION: On April 18, 1983, the Secretary transferred the authority for controlling fraud and abuse in the Medicare and Medicaid programs from HCFA to the Office of the Inspector General (OIG).

This change in delegation was reflected in final regulations published on September 13, 1985 (50 FR 37370), which amended HCFA regulations in Parts 420, 455, and 489. The OIG regulations published today transfer the rules pertaining to OIG authorities to a new 42 CFR Chapter V, and include material from Parts 412 and 474 as well as 420, 455, and 489.

This document further amends HCFA regulations as required by the removal of the content redesignated under the new 42 CFR Chapter V Specifically—

1. In § 412.48 (which deals with denial of Medicare payment) we removed paragraphs (d) and (e) and revised paragraph (c) to refer to § 1001.301 of the new OIG rules.

2. In Part 420 (Program Integrity: Medicare), we removed § 420.2 and revised §§ 420.1 and 420.3 to limit scope and applicability and cite the new OIG rules. We have vacated and reserved Subpart B. The content of Subpart B, pertaining to exclusion or suspension of practitioners, providers, or suppliers of services now appears in 42 CFR Chapter V, Part 1001, Subpart B.

3. In Part 455 (which deals with program integrity in Medicaid), we removed Subparts C and D; revised § 455.1 (Basis and scope) to limit the description of the scope to those aspects that remain in Part 455 because they continue to be HCFA's responsibility; and added a new § 455.3 to indicate that the rules on exclusion and suspension of providers and on Medicaid fruad control units are now in the OIG regulations.

4. In Part 466, which deals will utilization and quality control review, we added a new paragraph (f) to § 466.70 to indicate that the rules on PRO sanctions are now set forth in Part 1004 of the OIG regulations.

5. In Part 474, we removed Subparts C through G because they deal with matters for which the OIG now has responsibility. We removed Subpart B because it dealt with the Professional Standards Review Organization (PSRO) program and had become obsolete. The Peer Review Improvement Act of 1982 (Title I, Substitle C of Pub. L. 97-248)

amended Title XI of the Act to repeal the PSRO program and establish the Utilization and Quality Control Peer Review (PRO) program. HCFA began awarding contracts to PROs in June 1984. There are no longer any PSROs performing review functions in the Medicare program. All that remained of Part 474 was Subpart A, a single § 474.0 Scope and definitions. Since there is nothing left in Part 474 to which this section could apply, we vacated and reserved Part 474.

6. In § 489. 54, which deals with termination of provider agreements by the OIG, and is also reflected in the new Chapter V, we changed a cross-reference from § 420.105 through 420.109" to §§ 1001.105 through 1001.109 of this title".

Waiver of Notice and Delayed Effective Date

These rules merely conform Parts 412, 420, 455, 466, 474 and 489 of the HCFA rules to changes in the delegations of authority in order to avoid confusion and duplication. Accordingly, we find that notice and opportunity for public comment and delayed effective date are unnecessary, and find good cause to waive them.

Regulatory Impact Statement

Since we are merely conforming the HCFA rules to the changes made by other rules published today, these rules will have no appreciable impact. For that reasons, the requirements of Executive Order 12291, the Regulatory Flexibility Act, and Paperwork Reduction Act do not apply.

List of Subjects

42 CFR Part 412

Health facilities, Medicare.

42 CFR Part 420

Administrative practice and procedure, Fraud, Health facilities, Health professions, Medicare.

42 CFR Part 455

Fraud, Grant programs-health, Investigations, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 466

Grant programs-health, Health care, Health facilities, Health professions, Peer Review Organizations, Professional Standards Review Organizations (PSRO).

42 CFR Part 474

Administrative practice and procedures, Health care, Health professions Peer Review Organizations, Penalties, Professional Standards Review Organizations (PSRO), Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare.

42 CFR Chapter IV is amended as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES

A. 1. The authority citation for Part 412 continues to read as follows:

Authority: Secs. 1102, 1122, 1871, and 1886 of the Social Security Act (42 U.S.C. 1302, 1320a–1, 1395hh, and 1395ww)

2. Section 412.48 is amended by removing paragraphs (d) and (e), and revising paragraph (c) to read as follows:

§ 412.48 Denial of payment as a result of admissions and quality review.

* * * * *

(c) A determination under paragraph (a) of this section, if it is related to a pattern of inappropriate admissions and billing practices that has the effect of circumventing the prospective payment system, is referred to the Department's Office of Inspector General, for handling in accordance with § 1001.301 of this title.

B. 1. The heading of Part 420 is revised to read as follows:

PART 420—PROGRAM INTEGRITY: MEDICARE

2. The authority citation for Part 420 is revised to read as follows:

Authority: Secs. 1102, 1124, 1126, 1866, and 1871, of the Social Security Act (42 U.S.C. 1302, 1320a–3, 1320a–5, 1395cc, and 1395hh).

3. Subpart A is amended as follows:

Subpart A—General Provisions

a. Section 420.2 is removed and the table of contents is amended to reflect this change.

b. Sections 420.1 and 420.3 are revised to read as follows:

§ 420.1 Scope and purpose.

This part sets forth requirements for Medicare providers, intermediaries, and carriers to disclose ownership and control information. It also deals with access to records pertaining to certain contracts entered into by Medicare providers. These rules are aimed at protecting the integrity of the Medicare program. The statutory basis for these requirements is explained in each of the other subparts.

§ 420.3 Other related regulations.

(a) *Appeals procedures.* Subpart O of Part 405 of this chapter sets forth the appeals procedures available to providers whose provider agreements HCFA terminates for failure to comply with the disclosure of information requirements set forth in Subpart C of this part.

(b) *Exclusion, termination, or suspension.* Part 1001 of this title sets forth the rules applicable to exclusion, termination, or suspension from the Medicare program because of fraud or abuse or conviction of program-related crimes.

Subpart B—[Removed and Reserved]

4. Subpart B is removed and reserved and the table of contents is amended to reflect this change.

Subparts C and D—[Amended]

5. The authority citations in Subparts C and D are removed as inconsistent with the pattern of all Medicare and Medicaid rules except 42 CFR Part 405.

C. 1. The heading of Part 455 is revised to read as follows:

PART 455—PROGRAM INTEGRITY: MEDICAID

2. The authority citation for Part 455 is revised to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

3. Section 455.1 is amended by revising the undesignated introductory statement and paragraph (a) and removing paragraphs (c) and (d). As revised, § 455.1 reads as follows:

§ 455.1 Basis and scope.

This part sets forth requirements for a State fraud detection and investigation program, and for disclosure of information on ownership and control.

(a) Under the authority of sections 1902(a)(4), 1903(i)(2), and 1909 of the Social Security Act, Subpart A provides State plan requirements for the identification, investigation, and referral of suspected fraud and abuse cases. In addition, the subpart requires that the State (1) report fraud and abuse information to the Department and (2) have a method to verify whether services reimbursed by Medicaid were actually furnished to recipients.

(b) Subpart B implements sections 1124, 1126, 1902(a)(36), 1903(i)(2), and 1903(n) of the Act. It requires that providers and fiscal agents must agree to disclose ownership and control information to the Medicaid State agency.

§ 455.2 [Amended]

4. a. In the undesignated introductory statement, the phrase "Subparts A, B, C, and D of" is removed.

b. The definitions of "PRO" and "PSRO" are removed, the first because it duplicates § 400.200, the second as outdated.

5. A new § 455.3 is added to read as follows:

§ 455.3 Other applicable regulations.

Part 1002 of this title sets forth the following:

(a) State plan requirements for excluding providers for fraud and abuse, and suspending practitioners convicted of program-related crimes.

(b) The limitations on FFP for services furnished by excluded providers or suspended practitioners.

(c) The requirements and procedures for reinstatement after exclusion or suspension.

(d) Requirements for the establishment and operation of State Medicaid fraud control units and the rates of FFP for their fraud control activities.

§ 455.15 [Amended]

6. In paragraph (a)(1)—

a. "Subpart D of this part," is changed to "Subpart C of Part 1002 of this title,".

b. "§ 455.300(e); or" is changed to "§ 1002.309 of this title; or".

Subpart B—[Amended]

7. In Subpart B, the authority citation is removed as inconsistent with the pattern of other Medicaid rules.

§ 455.101 [Amended]

8. The definition of "Convicted" is removed as duplicative of the § 455.2 definition.

Subparts C and D—[Removed]

9. Subparts C and D are removed and the table of contents is amended to reflect this change.

PART 466—UTILIZATION AND QUALITY CONTROL REVIEW

1. The authority citation for Part 466 is revised to read as follows and the authority citations for § 466.1, and §§ 466.60 through 466.63 (preceding § 466.60), are removed:

Authority: Secs. 1102, 1154, and 1871 of the Social Security Act (42 U.S.C. 1302, 1302c–3, and 1395hh).

2. Section 466.70 is amended by adding a new paragraph (f), to read as follows:

§ 466.70 Statutory bases, applicability, and provisions.

* * * * *

(f) *Coordination of sanction activities.* The PRO must carry out the responsibilities specified in Subpart C of Part 1004 of this title regarding imposition of sanctions on providers and practitioners who violate their statutory obligations under section 1156 of the Act.

PART 474—IMPOSITION OF SANCTIONS ON HEALTH CARE, PRACTITIONERS AND PROVIDERS OF HEALTH CARE SERVICES—[Removed and Reserved]

E. Part 474 is removed and the table of contents of Chapter IV is amended to reflect this change.

PART 489—PROVIDER AGREEMENTS UNDER MEDICARE

F. 1. The authority citation for Part 489 is revised to read as follows:

Authority: Secs. 1102, 1861, 1864m 1866, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x, 1395aa, 1395cc, and 1395hh), and sec. 602(k) of Pub. L. 98–21 (42 U.S.C. 1395 ww note).

§ 489.54 [Amended]

2. In § 489.54(d), the cross reference is changed from "§§ 420.105 through 420.109" to "§§ 1001.105 through 1001.109".

(Catalog of Federal Domestic Assistance Programs No. 13.714, Medical Assistance Program; No. 13.773, Medicare-Hospital Insurance Program; No. 13.774, Medicare-Supplementary Medical Income Program).

Dated: June 13, 1986.

William L. Roper,

Administrator, Health Care Financing Administration.

Approved: September 15, 1986.

Otis R. Bowen,

Secretary.

[FR Doc. 86–21752 Filed 9–29–86; 8:45 am]

BILLING CODE 4120–01–M

Federal Register

Tuesday
September 30, 1986

Part V

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 400, 405, 413, 416, 417, 420, 421, 447, and 489

Medicare Program; Redesignation of Reasonable Cost Regulations; Final Rule With Comment Period

DEPARTMENT OF HEALTH AND HUMAN SERVICES

42 CFR Parts 400, 405, 413, 416, 417, 420, 421, 447, and 489

[BERC-369-FC]

Medicare Program; Redesignation of Reasonable Cost Regulations

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule with comment period.

SUMMARY: This rule redesignates most of the sections in Subpart D of 42 CFR Part 405 into a new Part 413. This redesignation is part of our overall plan for reorganization of the regulations in 42 CFR Part 405 in order to make them easier to locate and use. More specifically, we intend this redesignation to provide more adequate space for the complex policies and procedures regarding reasonable cost reimbursement that currently are compressed into Part 405, Subpart D.

DATES:

Effective: These regulation are effective October 1, 1986. They are being issued in final for reasons explained in the supplementary information section below.

Comment: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5:00 p.m. on December 1, 1986.

ADDRESS: Health Care Financing Administration, Department of Health and Human Services, Attention: BERC-369-FC, P.O. Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your comments to one of the following addresses:

Room 309-G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC, or

Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland.

In commenting, please refer to BERC-369-FC. Comments received timely will be available for public inspection as they are received, generally beginning approximately three weeks after publication of this document, in Room 309-G of the Department's offices at 200 Independence Avenue SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (phone: 202-245-7890).

FOR FURTHER INFORMATION CONTACT: Mike Fiore, (301) 594-9779.

SUPPLEMENTARY INFORMATION: In the Code of Federal Regulations (CFR), the main body of HCFA's rules are located in Title 42 (Public Health), Chapter IV (Health Care Financing Administration, Department of Health and Human Services), Parts 400-499. In Subpart D of Part 405, the rules that govern reasonable cost reimbursement are set forth. In this final rule, as part of the overall plan for the continuing reorganization of 42 CFR Chapter IV, we are redesignating most of the reasonable cost regulations located in Part 405, Subpart D into a new Part 413. As part of this process, we previously redesignated §§ 405.470 through 405.477 to a new Part 412 (50 FR 12740). Those regulations govern the prospective payment system for inpatient hospital services under Medicare.

The regulations sections being redesignated in this final rule are those that deal with reasonable cost reimbursement for Medicare providers, and special reimbursement rules for outpatient maintenance dialysis. The sections dealing with payments to teaching hospitals (§§ 405.465-405.466) and payments for services of physicians to providers (§§ 405.480-405.482) will be the subject of future redesignations.

In addition to the coding changes made by this redesignation, other changes in the final rule are for minor technical corrections, such as integrating regulations into a logical sequence and updating of cross-references throughout 42 CFR, or minor editorial revisions, such as correcting spelling and punctuation errors. In no instance do we intend any of the amendments to affect the substance of the Medicare rules.

Changes that require more specific explanation are discussed below:

Subpart A—Introduction and General Rules

In § 413.1(a) (§ 405.401), we added organ procurement agencies and histocompatability laboratories to the list of providers subject to reasonable cost reimbursement rules in Part 413. These facilities were not included in this introductory list, although discussed in subsequent regulations in Part 413 (Part 405, Subpart D).

Subpart G—Capital-Related Costs

1. In § 413.134(a)(3)(ii)(B) (§ 405.415), we added the specific effective date regarding the acquisition of depreciable assets.

2. In § 413.144 (§ 405.417), because paragraph (b) was lengthy and complex, we split it into paragraphs (b), (c), and (d) to make it easier to read.

Subpart H—Payment for End-Stage Renal Disease (ESRD) Services

1. We are deleting §§ 405.438 and 405.440 because these sections are time limited and were not applicable after July 31, 1983. We are also revising paragraph (g) of § 413.5 (§ 405.402) to delete obsolete material.

2. In § 413.170(h)(2) (§ 405.439), we substituted "Administrator" for "Secretary", because the Administrator of HCFA has been delegated the authority to review Provider Reimbursement Review Board decisions.

3. In § 413.174(a) (§ 405.441), we deleted the references to the Office of Management and Budget approval numbers for HCFA forms 2552 and 265. We do not normally include in regulations text approval numbers for HCFA forms because these forms may be revised periodically or become obsolete, which would require us to further amend the regulations text.

4. In § 413.178(c)(2), (§ 405.436), we added the specific effective date regarding agreements filed by organ procurement agencies and histocompatability laboratories. The following table displays the current section coding and the redesignated coding.

REDESIGNATION TABLE FOR 42 CFR 405.401 THROUGH 405.463

Old section	New section
405.401	413.1
405.402	413.5
405.403	413.50
405.405	413.60
405.406	413.20
405.414	413.130
405.415	413.134
405.416	413.139
405.417	413.144
405.418	413.149
405.419	413.153
405.420	413.80
405.421	413.85
405.422	413.90
405.424	413.94
405.425	413.98
405.426	413.102
405.427	413.17
405.429	413.157
405.432	413.106
405.433	413.110
405.434	413.114
405.435	413.161
405.436	413.178
405.438	[1]
405.439	413.170
405.440	[1]
405.441	413.174
405.451	413.9
405.452	413.53
405.453	413.24
405.454	413.64
405.455	413.13
405.456	413.74
405.457	413.56
405.460	413.30
405.461	413.35
405.463	413.40

[1] Deleted.

Regulatory Impact Statement

We have determined that this is not a major rule under Exective Order 12291. In addition, the Secretary certifies that

this redesignation will not have a significant economic impact on a substantial number of small entities. Therefore, we have prepared neither a regulatory impact analysis under E.O. 12291 nor a regulatory flexibility analysis under the Regulatory Flexibility Act of 1980 (5 U.S.C. 601 through 612).

Waiver of Proposed Rulemaking

The changes made by this redesignation are minor, and of an editorial nature. Because these changes do not alter any Medicare policies or procedures, the usual notice and opportunity for prior public comment are unnecessary and we find good cause to waive notice of proposed rulemaking. However, we are furnishing a subsequent public comment period limited to the issue of whether we inadvertently made a substantive change in this redesignation. If, during the comment period, we receive information concerning substantive errors or omissions that have occurred in the redesignation, we will correct them in a later documemt.

Waiver of 30-day Delay in the Effective Date

As noted above, the regulations are effective October 1, 1986. If we were to provide the customary 30-day delay in the effective date, the next updated issue of Title 42 of the CFR, which is revised as of October 1, 1986, would show two sets of extensive, essentially duplicative regulations text regarding reasonable cost reimbursement. One set would continue to be located in Subpart D of 42 CFR Part 405, which would remain in effect through the 30-day period. The second set would be located in the new 42 CFR Part 413, which would be effective after the 30-day period had expired. Such a confusing and perverse effect would be unintended but would result from the interaction of a 30-day delay in the effective date of this final rule and the annual date of revision of 42 CFR. Therefore, the usual delay in effective date is impractical. In addition, because we are not revising the regulations, but merely redesignating them, the delay is unnecessary. Accordingly, we find good cause to waive the delay in the effective date of this final rule.

Information Collection Requirements

These provisions do not impose information collection requirements; consequently, they need not be reviewed by the Executive Office of Management and Budget under the authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 through 3511).

List of Subjects

42 CFR Part 400

Grant programs-health, Health facilities, Health Maintenance Organizations (HMO), Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Nursing homes, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 413

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Nursing homes, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 416

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 417

Administrative practice and procedures, Health Maintenance Organization (HMO), Medicare.

42 CFR Part 420

Administrative practice and procedure, Fraud, Health facilities, Health professions, Medicare.

42 CFR Part 421

Administrative practice and procedure, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 447

Accounting, Administrative practice and procedure, Grant programs—health, Health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements, Rural areas.

42 CFR Part 489

Health facilities, Medicare.

42 CFR Chapter IV is amended as set forth below:

I. The table of contents for Chapter IV is amended by adding the title of a new Part 413 to Subchapter B to read as follows:

CHAPTER IV—HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

* * * * *

Subchapter B—Medicare Programs

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES

* * * * *

II. Part 400 is amended as follows:

PART 400—INTRODUCTION; DEFINITIONS

Subpart C—OMB Control Numbers for Approved Collections of Information

A. The authority citation for Part 400 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh) and 44 U.S.C. Chapter 35.

§ 400.310 [Amended]

B. In § 400.310, reference to "§ 405.460" is changed to read "§ 413.30."

III. Part 405 is amended as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

A. Subpart A is amended as follows:

Subpart A—Hospital Insurance Benefits

1. The authority citation for Subpart A continues to read as follows:

Authority: Secs. 1102, 1814, 1815, 1861, 1866(d), and 1871 of the Social Security Act as amended (42 U.S.C. 1302, 1395f, 1395g, 1395x, 1395cc(d), and 1395hh).

§ 405.153 [Amended]

2. In § 405.153(c)(1), reference to "§ 405.456" is changed to read § 413.74 of this chapter."

B. Subpart B is amended as follows:

Subpart B—Supplementary Medical Insurance Benefits; Enrollment, Coverage, Exclusions, and Payment

1. The authority citation for Subpart B is revised to read as follows:

Authority: Secs. 1102, 1831–1843, 1861, 1862, 1866, and 1871 of the Social Security Act as amended (42 U.S.C. 1302, 1395j–1395v, 1395x, 1395y, 1395cc, and 1395hh), unless otherwise noted.

§ 405.240 [Amended]

2. In § 405.240(i)(1), reference to "§ 405.439" is changed to read "§ 413.170 of this chapter."

§ 405.260 [Amended]

3. In § 405.260(a), reference to "Subpart D" is changed to read "Part 413 of this chapter."

C. Subpart C is amended as follows:

Subpart C—Exclusions, Recovery of Overpayment, Liability of a Certifying Officer and Suspension of Payment

1. The authority citation for Subpart C continues to read as follows:

Authority: Secs. 1102, 1815, 1833, 1842, 1861, 1862, 1866, 1870, 1871, and 1879 of the Social Security Act (42 U.S.C. 1302, 1395g, 1395l, 1395u, 1395x, 1395y, 1395cc, 1395gg, 1395hh, and 1395pp), and 31 U.S.C. 3711.

§ 405.343 [Amended]

2. In § 405.343, reference to "§ 405.461" is changed to read "§ 413.35 of this chapter."

§ 405.376 [Amended]

3. a. In § 405.376(c)(1)(ii), reference to "42 CFR 405.454(f)(2)" is changed to read "§ 413.64(f)(2) of this chapter."

b. In § 405.376(e)(3), reference to "§ 405.453(f)" is changed to read "§ 413.24(f) of this chapter."

c. In § 405.376(h)(1), reference to "§ 405.454(l)" is changed to read "§ 413.64(j) of this chapter."

d. In § 405.376(i), reference to "§ 405.419" is changed to read "§ 413.153 of this chapter," and the reference to "§ 405.419(a)(2)" is changed to read "§ 413.153(a)(2) of this chapter."

D. Subpart D is amended as follows:

1. The authority citation for Subpart D is revised to read as follows:

Authority: Secs. 1102, 1871, and 1887 of the Social Security Act as amended (42 U.S.C. 1302, 1395hh, and 1395xx).

2. The title of Subpart D is revised to read as follows:

Subpart D—Principles of Reimbursement for Services by Hospital-Based Physicians

3. The table of contents for Subpart D is revised by removing the titles of §§ 405.401 through 405.463 and the undesignated center headings preceding those sections.

§§ 405.401 through 405.463 [Amended]

4. Sections 405.401 through 405.463 are revised and redesignated as new §§ 413.1 through 413.178, as set forth below in new Part 413. The undesignated center headings preceding those sections are removed.

§ 405.465 [Amended]

5. a. In § 405.465, all references to "§ 405.427" are changed to read "§ 413.17 of this chapter."

b. In § 405.465(e)(1), reference to "§ 405.453" is changed to read "§ 413.24 of this chapter."

§ 405.480 [Amended]

6. a. In § 405.480, the introductory text to paragraph (a), reference to "§ 405.426" is changed to read "§ 413.102 of this chapter."

b. In § 405.480(a)(4), reference to "§ 405.451" is changed to read "§ 413.9 of this chapter."

§ 405.481 [Amended]

7. In § 405.481, paragraphs (a) and (d)(2), references to "42 CFR 405.427" and § 405.427", respectively, are changed to read "§ 413.17 of this chapter."

E. Subpart E is amended as follows:

Subpart E—Criteria for Determination of Reasonable Charges, Reimbursement for Services of Hospital Interns, Residents, and Supervising Physicians

1. The authority citation for Subpart E continues to read as follows:

Authority: Secs. 1102, 1814(b), 1832, 1833(a), 1842 (b) and (h), 1861 (b) and (v), 1862(a)(14), 1866(a), 1871, 1881, 1886, and 1887 of the Social Security Act as amended (42 U.S.C. 1302, 1395f(b), 1395k, 1395l(a), 1395u(b) and (h), 1395x(b) and (v), 1395y(a)(14), 1395cc(a), 1395hh, 1395rr, 1395ww, and 1395xx).

§ 405.501 [Amended]

2. In § 405.501(b), reference to "Subpart D of this part" is changed to read "Part 413 of this chapter."

§ 405.502 [Amended]

3. In § 405.502, paragraphs (e)(2) and (e)(3), reference to "§§ 405.439 and 405.544" is changed to read "§ 405.544 and § 413–170 of this chapter." Also, in paragraph (e)(3) of § 405.502, reference to "Subpart D of this part" is changed to read "Part 413 of this chapter."

§ 405.521 [Amended]

4. In § 405.521(d)(1), reference to "§ 405.421 of Subpart D of this part" is changed to read "§ 413.85 of this chapter."

§ 405.522 [Amended]

5. In § 405.522(b), references to "Subpart D of this part" are changed to read "Part 413 of this chapter."

§ 405.525 [Amended]

6. In § 405.525, in footnote three to the table, reference to "Subpart D of this part" is changed to read "Part 413 of this chapter."

§ 405.541 [Amended]

7. a. In § 405.541(a)(1), reference to "§ 405.439 and 405.544" is changed to read "§ 405.544 and § 413.170 of this chapter."

b. In § 405.541(e), reference to "§ 405.439(f)" is changed to read "§ 413.170(f) of this chapter."

c. In § 405.541(f)(2), reference to "§ 405.406" is changed to read "§ 413.20 of this chapter."

d. In § 405.541(f)(3), reference to "§ 405.441" is changed to read "§ 413.174 of this chapter."

§ 405.544 [Amended]

8. a. In § 405.544, all references to "Subpart D of this part" are changed to read "Part 413 of this chapter."

b. In § 405.544, all references to "§ 405.439" are changed to read "§ 413.170 of this chapter."

§ 405.550 [Amended]

9. a. In § 405.550(e)(2), reference to "Subpart D of this part" is changed to read "Part 413 of this chapter."

b. In § 405.550(e)(3), reference to "§ 405.427" is changed to read "§ 413.17 of this chapter."

§ 405.556 [Amended]

10. In § 405.556(c), reference to "Subpart D" is changed to read "Part 413 of this chapter."

F. Subpart F is amended as follows:

Subpart F—Notice, Election and Agreements

1. The authority citation for Subpart F continues to read as follows:

Authority: Secs. 1102, 1816, 1842, 1861(u), 1864, 1866, 1871, and 1881, of the Social Security Act (42 U.S.C. 1302, 1395h, 1395u, 1395x(u), 1395aa, 1395cc, 1395hh, and 1395rr), unless otherwise noted.

§ 405.658 [Amended]

2. In § 405.658(b)(3), reference to "§ 405.456" is changed to read "§ 413.74 of this chapter."

§ 405.691 [Amended]

3. In § 405.691(a), reference to "§ 405.439" is changed to read "§ 413.170 of this chapter."

G. Subpart P is amended as follows:

Subpart P—Certification and Recertification; Claims and Benefit Payment Requirements; Check Replacement Procedures

1. The authority citation for Subpart P continues to read as follows:

Authority: Secs. 1102, 1814, 1835, 1871, and 1883 of the Social Security Act, as amended (42 U.S.C. 1302, 1395f, 1395n, 1395hh, and 1395tt).

§ 405.1682 [Amended]

2. In § 405.1682(c), reference to "§ 405.454(k)" is changed to read "§ 413.64(i) of this chapter."

H. Subpart R is amended as follows:

Subpart R—Provider Reimbursement Determinations and Appeals

1. The authority citation for Subpart R continues to read as follows:

Authority: Secs. 205, 1102, 1814(b), 1815(a), 1833, 1861(v), 1871, 1872, 1878, and 1886 of the Social Security Act (42 U.S.C. 405, 1302, 1395f(b), 1395g(a), 1395l, 1395x(v), 1395hh, 1395ii, 1395oo, and 1395ww).

§ 405.1801 [Amended]

2. a. In § 405.1801(a)(1), reference to "§ 405.406" is changed to read "§ 413.20 of this chapter."

b. In § 405.1801, references to "§ 405.453(f)" are changed to read "§ 413.24(f) of this chapter."

c. In § 405.1801(b)(1), reference to "Subpart D of this part" is changed to read "Parts 413 and 412, respectively, of this chapter."

§ 405.1803 [Amended]

3. In § 405.1803(c), reference to "§ 405.454(f)" is changed to read "§ 413.64(f) of this chapter."

§ 405.1805 [Amended]

4. In § 405.1805, reference to "§ 405.427" is changed to read "§ 413.17 of this chapter."

§ 405.1841 [Amended]

5. In § 405.1841(a)(2), reference to "§ 405.427" is changed to read "§ 413.17 of this chapter."

§ 405.1877 [Amended]

6. In § 405.1877, paragraphs (e) and (f), reference to "§ 405.427" is changed to read "§ 413.17 of this chapter."

IV. Part 412 is amended as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES

A. The authority citation continues to read as follows:

Authority: Secs. 1102, 1122, 1871, and 1886 of the Social Security Act (42 U.S.C. 1302, 1320a–1, 1395hh, and 1395ww).

B. Subpart A is amended as follows:

Subpart A—General Provisions

§ 412.2 [Amended]

1. a. In § 412.2 (c)(1) and (c)(3), references to "§ 405.452(b)" are changed to read "§ 413.55(b)."

b. In § 412.2(d)(1), reference to "§§ 405.414 and 405.429" is changed to read "§§413.130 and 413.157, respectively."

c. In § 412.2(d)(2), reference to "§ 405.421" is changed to read "§ 413.85."

§ 412.6 [Amended]

2. a. In § 412.6(a)(3), reference to "Subpart D of Part 405" is changed to "Part 413."

b. In § 412.6(b), reference to "§ 405.453(f)(3)" is changed to read "§ 413.24(f)(3)."

C. Subpart B is amended as follows:

Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment System

§ 412.22 [Amended]

1. In § 412.22(b) reference to "Subpart D of Part 405" is changed to read "Part 413" and reference to "§ 405.463" is changed to read "§ 413.40."

D. Subpart C is amended as follows:

Subpart C—Conditions for Payment Under the Prospective Payment System

§ 412.52 [Amended]

1. In § 412.52, reference to "§§405.406 and 405.453" is changed to read "§413.20 and 413.24."

E. Subpart D is amended as follows:

Subpart D—Basic Methodology for Determining Federal Prospective Payment Rates

§ 412.62 [Amended]

1. In § 412.62(c)(2), reference to "§ 405.463(c)(3), is changed to read "§ 413.40(c)(3)."

§ 412.63 [Amended]

2. In § 412.63(c)(2)(i), reference to "§405.463(c)" is changed to read "413.40(c)."

F. Subpart E is amended as follows:

Subpart E—Determination of Transition Period Payment Rates

§ 412.71 [Amended]

1. a. In § 412.71, the introductory paragraph to paragraph (b), reference to "§ 405.452" is changed to read "§ 413.55."

b. In § 412.71(b)(2), reference to "§ 405.421" is changed to read "§ 413.85."

c. In § 412.71(b)(3), reference to "§ 405.414" is changed to read "§ 413.130."

§ 412.73 [Amended]

2. a. In § 412.73(b)(2), reference to "§ 405.460" is changed to read "§ 413.30."

b. In § 412.73, paragraphs (c)(1) and (c)(3), reference to "§ 405.463(c)(3)" is changed to read "§ 413.40(c)(3)."

G. Subpart G is amended as follows:

Subpart G—Special Treatment of Certain Facilities

§ 412.92 [Amended]

1. a. In § 412.92(b)(4), reference to "§ 405.460(e)(1)" is changed to read "§ 413.30(e)(1)."

b. In § 412.92(e)(3)(ii), reference to "Subpart D of Part 405" is changed to read "Part 413."

§ 412.94 [Amended]

2. In § 412.94(b)(1), reference to "Subpart D of Part 405" is changed to read "Part 413." Also in the same paragraph, reference to "§ 405.463" is changed to read "§ 413.40."

§ 412.98 [Amended]

3. In § 412.98(b), reference to "§ 405.463(c)(4)" is changed to read "§ 413.40(c)(4)" and reference to "§ 405.463" is changed to read "§ 413.40."

H. Subpart H is amended as follows:

Subpart H—Payments to Hospitals Under the Prospective Payment System

§ 412.113 [Amended]

1. a. § 412.113(a), reference to "§ 405.414" is changed to read "§ 413.130."

b. In § 412.113(b), reference to "§ 405.421" is changed to read "§ 413.85." Also in the same paragraph, references to "§ 405.421(a)" and "§ 405.421(d)" are changed to read "§ 413.85(a)" and "§ 413.85(d), respectively".

§ 412.115 [Amended]

2. In § 412.115(a), reference to "§ 405.420" is changed to read "§ 413.80."

§ 412.118 [Amended]

3. In § 412.118(e)(1), reference to "§ 405.421" is changed to read "§ 413.85."

V. A new Part 413 is added to read as folows:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES

Subpart A—Introduction and General Rules

Sec.

Authority: Sections 1102, 1122, 1814(b), 1815, 1833(a), 1861(v), 1871, 1881, and 1886 of the Social Security Act as amended (42 U.S.C. 1302, 1320a–1, 1395f(b), 1395g, 1395l(a), 1395x(v), 1395hh, 1395rr, and 1395ww).

Subpart A—Introduction and General Rules

§ 413.1 Introduction.

(a) *Scope*—(1) *General summary.* This part sets forth regulations governing Medicare payment for services furnished to beneficiaries by—

(i) Hospitals;

(ii) Skilled nursing facilities (SNFs);

(iii) Home health agencies (HHAs);

(iv) Comprehensive outpatient rehabilitation facilities (CORFs);

(v) End-stage renal disease (ESRD) facilities;

(vi) Providers of outpatient physical therapy and speech pathology services (OPTs); and

(vii) organ procurement agencies (OPAs) and histocompatibility laboratories.

(2) *Applicability.* The principles of payment and the related policies described in this subpart apply to HCFA, to the fiscal intermediaries acting as payors of claims on HCFA's behalf, to the Provider Reimbursement Review Board, and to the hospitals, SNFs, HHAs, CORFs, ESRD facilities, OPTs, OPAs, and histocompatibility laboratories receiving payment under this part.

(b) *Reasonable cost reimbursement.* Except as provided under paragraphs (c) through (e) of this section, Medicare is generally required, under section 1814(b) of the Act (for services covered under Part A) and under section 1833(a)(2) of the Act (for services covered under Part B) to pay for services furnished by providers on the basis of reasonable costs as defined in section 1861(v) of the Act, or the provider's customary charges for those services, if lower. Regulations implementing section 1861(v) are found generally in this part beginning at §413.5.

(c) *Outpatient maintenance dialysis and related services.* Section 1881 of the Act authorizes special rules for the coverage of and payment for services furnished to ESRD patients. Sections 413.170 and 413.174 implement various provisions of section 1881. In particular § 413.170 establishes a prospective payment method for outpatient maintenance dialysis services that applies both to hospital-based and independent ESRD facilities, and under which Medicare pays for both home and infacility dialysis services furnished on or after August 1, 1983.

(d) *Payment for impatient hospital services.* (1) For cost reporting periods beginning before October 1, 1983, the amount paid for inpatient hospital services is determined on a reasonable cost basis.

(2) For cost reporting periods beginning on or after October 1, 1983, payment to short-term general hospitals located in the 50 States and the District of Columbia for the operating costs of inpatient hospital services is determined prospectively on a per discharge basis under Part 412 of this chapter except as follows:

(i) Payment for capital-related, medical education, and kidney acquisition costs, and the costs of certain anesthesis services, is described in § 412.113 of this chapter.

(ii) Payment to children's, psychiatric, rehabilitation and long-term hospitals (as well as separate psychiatric and rehabilitation units (distinct parts) of short-term general hospitals), which are excluded from the prospective payment system under Subpart B of Part 412 of this chapter, and to hospitals outside the 50 States and the District of Columbia is on a reasonable cost basis, subject to the provisions of § 413.40.

(iii) Payment to hospitals subject to a State reimbursement control system is described in paragraph (e) of this section.

(e) *State reimbursement control systems.* Beginning October 1, 1983, Medicare reimbursement for inpatient hospital services may be made in accordance with a State reimbursement control system rather than under the Medicare reimbursement principles set forth in this part, if the State system is approved by HCFA. Regulations implementing this alternative reimbursement authority are set forth in Subpart C of Part 403 of this chapter.

§ 413.5 Cost reimbursement: General.

(a) In formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate. All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. Furthermore, the share of the total institutional cost that is borne by the program is related to the care furnished beneficiaries so that no part of their cost would need to be borne by other patients. Conversely, costs attributable to other patients of the institution are not to be borne by the program. Thus, the application of this approach, with appropriate accounting support, will result in meeting actual costs of services to beneficiaries as such costs vary from institution to institution.

However, payments to providers of services for services furnished Medicare beneficiaries are subject to the provisions of §§ 413.13 and 413.30.

(b) Putting these several points together, certain tests have been evolved for the principles of reimbursement and certain goals have been established that they should be designed to accomplish. In general terms, these are the tests or objectives:

(1) That the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement.

(2) That, in addition to current payment, there should be retroactive adjustment so that increases in costs are taken fully into account as they actually occurred, not just prospectively.

(3) That there be a division of the allowable costs between the beneficiaries of this program and the other patients of the provider that takes account of the actual use of services by the beneficiaries of this program and that is fair to each provider individually.

(4) That there be sufficient flexibility in the methods of reimbursement to be used, particularly at the beginning of the program, to take account of the great differences in the present state of development of recordkeeping.

(5) That the principles should result in the equitable treatment of both nonprofit organizations and profit-making organizations.

(6) That there should be a recognition of the need of hospitals and other providers to keep pace with growing needs and to make improvements.

(c) As formulated herein, the principles give recognition to such factors as depreciation, interest, bad debts, educational costs, compensation of owners, and an allowance for a reasonable return on equity capital of proprietary facilities. However, costs such as depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary providers), and other costs related to certain capital expenditures are subject to the provisions of § 413.161, "Nonallowable costs related to certain capital expenditures." With respect to allowable costs some items of inclusion and exclusion are:

(1) An appropriate part of the net cost of approved educational activities will be included.

(2) Costs incurred for research purposes, over and above usual patient care, will not be included.

(3) Grants, gifts and income from endowments will not be deducted from operating costs unless they are designated by the donor for the payment of specific operating costs.

(4) The value of services provided by nonpaid workers, as members of an organization (including services or members of religious orders) having an agreement with the provider to furnish such services, is includable in the amount that would be paid others for similar work.

(5) Discounts and allowances received on the purchase of goods or services are reductions of the cost to which they relate.

(6) Bad debts growing out of the failure of a beneficiary to pay the deductible, or the coinsurance, will be reimbursed (after bona fide efforts at collection).

(7) Charity and courtesy allowances are not includable, although "fringe benefit" allowances for employees under a formal plan will be includable as part of their compensation.

(8) A reasonable allowance of compensation for the services of owners in profitmaking organizations will be allowed providing their services are actually performed in a necessary function.

(9) Reasonable cost of physicians' direct medical and surgical services (including supervision of interns and residents in the care of individual patients) furnished in a teaching hospital may be reimbursed as a provider cost (as described in § 405.465 of this chapter) where elected as provided for in § 405.521 of this chapter.

(d) In developing these principles of reimbursement for the Medicare program, all of the considerations inherent in allowances for depreciation were studied. The principles, as presented, provide options to meet varied situations. Depreciation will essentially be on an historical cost basis but since many institutions do not have adequate records of old assets, the principles provide an optional allowance in lieu of such depreciation for assets acquired before 1966. For assets acquired after 1965, the historical cost basis must be used. All assets actually in use for production of services for Medicare beneficiaries will be recognized even though they may have been fully or partially depreciated for other purposes. Assets financed with public funds may be depreciated. Although funding of depreciation is not required, there is an incentive for it since income from funded depreciation is not considered as an offset which must be taken to reduce the interest expense that is allowable as a program cost.

(e) A return on the equity capital of proprietary facilities, as described in § 413.157, is an allowable cost in profit-making organizations. The rate of return may not exceed one and one-half times the average long-term rate of interest on obligations issued for purchase by the Medicare Part A Trust Fund.

(f) Renal dialysis items and services furnished under the ESRD provision are reimbursed and reported under § 413.170 and 413.174 respectively. For special rules concerning health maintenance organizations (HMOs), and providers of services and other health care facilities that are owned or operated by an HMO, or related to an HMO by common ownership or control, see § 417.242(b)(14) and 417.250(c).

§ 413.9 Cost related to patient care.

(a) *Principle.* All payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost. However, for cost reporting periods beginning after December 31, 1973, payments to providers of services are based on the lesser of the reasonable cost of services covered under Medicare and furnished to program beneficiaries or the customary charges to the general public for such services, as provided for in § 413.13.

(b) *Definitions*—(1) *Reasonable Cost.* Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this part take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered services, from both Medicare and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of

services furnished to beneficiaries during the year.

(2) *Necessary and proper costs.* Necessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity.

(c) *Application.* (1) It is the intent of Medicare that payments to providers of services should be fair to the providers, to the contributors to the Medicare trust funds, and to other patients.

(2) The costs of providers' services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The provision in Medicare for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. This is subject to a limitation if a particular institution's costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors.

(3) The determination of reasonable cost of services must be based on cost related to the care of Medicare beneficiaries. Reasonable cost includes all necessary and proper expenses incurred in furnishing services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, if the provider's operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts will not be allowable. The reasonable cost basis of reimbursement contemplates that the providers of services would be reimbursed the actual costs of providing quality care however widely the actual costs may vary from provider to provider and from time to time for the same provider.

§ 413.13 Amount of payments if customary charges for services furnished are less than reasonable cost.

(a) *Principle.* Providers of services, other than CORFs and hospices, are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by the provider for the same services. (Payment to CORFs is based on the reasonable cost of services.) Public providers of service furnishing services free of charge or at a nominal charge are paid fair compensation for services furnished to beneficiaries. This principle is applicable to services furnished by providers in cost reporting periods beginning after December 31, 1973. This principle does not apply to payments for the costs of Part A inpatient hospital services for cost reporting periods subject to the rate of increase ceiling under § 413.40 or the prospective payment system under Part 412 of this chapter. However, the carryover from previous periods is recognized, subject to the provisions of paragraph (d) of this section. For special rules concerning HMOs and providers of services and other health facilities that are owned or operated by an HMO, or related to an HMO by common ownership or control, see §§ 417.242(b)(14) and 417.250(c) of this chapter.

(b) *Definitions*—(1) *Customary charges.* Customary charges for services furnished to beneficiaries are the charges as defined in § 413.53(b). Such charges must be recorded on all bills submitted for program reimbursement. If the provider does not actually impose such charges in the case of most patients liable for payment for its services on a charge basis or fails to make reasonable efforts to collect such charges from patients liable for payment for its services on a charge basis, customary charges for services furnished to beneficiaries will be the charges as defined in § 413.53(b) and recorded on the bills submitted for program reimbursement reduced in proportion to the ratio of the aggregate amount actually collected from patients liable for payment for services on a charge basis to the amounts that would be realized had charges consistent with the charges as defined in § 413.53(b) and recorded on the bills submitted for program reimbursement been paid by or on behalf of all patients liable for payment on a charge basis.

(2) *Reasonable cost.* For purposes of comparison with customary charges, the reasonable cost of services furnished to beneficiaries will exclude—(i) Payments made to a provider as reimbursement for bad debts arising from noncollection of Medicare deductible and coinsurance amounts; (ii) Amounts that represent the recovery of excess depreciation resulting from termination, or a decrease in Medicare utilization (§ 413.134(d)(3)) applicable to prior cost periods; (iii) Amounts applicable to prior cost periods resulting from disposition of depreciable assets (§ 413.134(f)); and (iv) Payments to funds for the donated services of teaching physicians.

(3) *Public provider.* A public provider means any provider operated by a Federal, State, county, city, or other local Government agency or instrumentality.

(4) *Nominal charges.* A public provider's charges are considered nominal if the aggregate charges are less than one-half of the reasonable cost of services or items represented by such charges.

(5) *New provider.* A new provider is an institution that has operated as the type of facility for which it is certified in the program (or the equivalent thereof) under present and previous ownership for less than three full years.

(c) *Aggregation of charges.* It is appropriate that, on an aggregate basis, payments to a provider for covered services furnished beneficiaries under Medicare should not exceed the customary charges made by the provider to the general public for the same services. In comparing charges and costs, customary charges for items and services, and the reasonable cost of such items and services will be aggregated, without regard to whether the related services were reimbursable under Part A or Part B of Medicare. The principle established is be applied after the provider's charges and costs have been adjusted in accordance with the requirements set forth in paragraph (b)(2) of this section and in §§ 405.480 through 405.482 of this chapter, to exclude any amounts attributable to physicians' services not reimbursable to the provider on a reasonable cost basis and to exclude costs and charges with respect to noncovered provider services.

Example. The reasonable cost of covered services furnished to program beneficiaries by a provider for a cost reporting period is $125,000. The customary charges to these beneficiaries for these services totaled $110,000. The amount to be reimbursed this provider will be $110,000 less deductible and coinsurance amounts to be borne by program beneficiaries.

(d) *Accumulation of unreimbursed costs and carryover to subsequent periods*—(1) *General.* Any provider of services whose charges are lower than costs in any cost reporting period beginning after December 31, 1973, may carry forward costs attributable to program beneficiaries that are unreimbursed under the provisions of this section for the two succeeding reporting periods. If beneficiary charges exceed reasonable cost in such subsequent periods, such previously

unreimbursed amounts carried forward will be reimbursed to the provider to the extent that such previously unreimbursed amounts carried forward, together with costs applicable to program beneficiaries in such subsequent periods, do not exceed customary charges with respect to services to program beneficiaries in such subsequent periods. If such two succeeding cost reporting periods combined include fewer than 24 full calendar months, the provider may carry forward costs unreimbursed under this section for one additional reporting period. However, no recovery may be made in any period in which costs are unreimbursed under §§ 413.30 or 413.40.

Example. In the reporting period ending December 31, 1974, the provider's reimbursable costs attributable to covered services furnished program beneficaries were $100,000. The provider's customary charges for these services were $90,000. The provider will, therefore, be reimbursed $90,000 less any deductible and coinsurance amounts but will be permitted to carry the unreimbursed $10,000 forward for the next two succeeding reporting periods. If, in the reporting period ending December 31, 1975, the charges to beneficiaries for covered services exceeded the reimbursable reasonable costs of such services by $10,000 or more, the provider could recover the entire $10,000 previously not reimbursed. If, however beneficiary charges exceeded costs by $8,000, this amount would be added to the provider's reimbursable costs for this period. The balance of the unreimbursed amount or $2,000 would be carried over to the next reporting period.

(2) *New provider*—(i) *General.* A new provider of services may carry forward for five succeeding cost reporting periods costs attributable to program beneficiaries that are unreimbursed under the provisions of this section during a base period, which includes any cost reporting period that begins after December 31, 1973, and ends on or before the last day of its third year of operation. If beneficiary charges exceed reasonable cost in the five succeeding reporting periods, such previously unreimbursed amounts carried forward will be reimbursed to the provider to the extent that such previously unreimbursed amounts carried forward, together with costs applicable to program beneficiaries in such subsequent periods, do not exceed customary charges with respect to services to program beneficiaries in such subsequent periods. If such five succeeding cost reporting periods combined include fewer than 60 full calendar months, the provider may carry forward costs unreimbursed under this section for one additional reporting period.

Example. A provider begins its operations on March 5, 1972. However, it begins to participate in the Medicare program as of January 1, 1973, and reports on a calendar year basis. Since it would be subject to the application of the provision for its cost reporting period beginning with January 1, 1974, it would be permitted to accumulate any unreimbursed costs (excess of cost over its charges) incurred during this reporting period. Since this cost reporting period ends before the end of the third year of operation, its carryover period will be the succeeding five cost reporting periods ending with December 31, 1979. Had this provider begun its operation on July 1, 1973, and become a participating provider as of the same date (with a fiscal year ending June 30), it would have been able to accumulate any unreimbursed costs for the two cost reporting periods ending June 30, 1975, and June 30, 1976. Its carryover period would then be the five cost reporting periods ending no later than June 30, 1981, in the case of costs unreimbursed in either of the reporting periods ending June 30, 1975, and June 30, 1976.

(ii) *New provider base period: Unreimbursed costs under lower of cost or charges.* If costs of a new provider are unreimbursed under this section, such previously unreimbursed amounts that a provider may recover during any cost reporting period in the new provider base period or carry forward period is limited to the amount by which the aggregate customary charges applicable to Medicare beneficiaries during any such period exceed the aggregate costs applicable to such beneficiaries during that period, except that no recovery may be made in any period in which costs are unreimbursed under §§ 413.110 or 413.116.

(e) *Public providers.* Fair compensation to public providers furnishing services free of charge or at nominal charges, as defined in paragraph (b)(4) of this section, for the services they furnish will be the reasonable costs of covered services, as defined in this part.

§ 413.17 Cost to related organizations.

(a) *Principle.* Except as provided in paragraph (d) below, costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

(b) *Definitions*—(1) *Related to the provider.* Related to the provider means that the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) *Common ownership.* Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

(3) *Control.* Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

(c) *Application.* (1) Individuals and organizations associate with others for various reasons and by various means. Some deem it appropriate to do so to assure a steady flow of supplies or services, to reduce competition, to gain a tax advantage, to exstend influence, and for other reasons. These goals may be accomplished by means of ownership or control, by financial assistance, by management assistance, and other ways.

(2) If the provider obtains items of services, facilities, or supplies from an organization, even though it is a separate legal entity, and the organization is owned or controlled by the owner(s) of the provider, in effect the items are obtained from itself. An example would be a corporation building a hospital or a nursing home and then leasing it to another corporation controlled by the owner. Therefore, reimbursable cost should include the costs for these items at the cost to the supplying organization. However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost to the provider may not exceed the market price.

(d) *Exception.* (1) An exception is provided to this general principle if the provider demonstrates by convincing evidence to the satisfaction of the fiscal intermediary (or, if the provider has not nominated a fiscal intermediary, HCFA), that (i) The supplying organization is a bona fide separate organization; (ii) A substantial part of its business activity of the type carried on with the provider is transacted with others than the provider and organizations related to the supplier by common ownership or control and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization; (iii) The services, facilities, or supplies are those that commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care ordinarily

furnished directly to patients by such institutions; and (iv) The charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies. (2) In such cases, the charge by the supplier to the provider for such services, facilities, or supplies is allowable as cost.

Subpart B—Accounting Records and Reports

§ 413.20 Financial data and reports.

(a) *General.* The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basis accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries.

(b) *Frequency of cost reports.* Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. In the interpretation and application of the principles of reimbursement, the fiscal intermediaries will be an important source of consultative assistance to providers and will be available to deal with questions and problems on a day-to-day basis.

(c) *Recordkeeping requirements for new providers.* A newly participating provider of services (as defined in § 400.202 of this chapter) must make available to its selected intermediary for examination its fiscal and other records for the purpose of determining such provider's ongoing recordkeeping capability and inform the intermediary of the date its initial Medicare cost reporting period ends. This examination is intended to assure that—(1) The provider has an adequate ongoing system for furnishing the records needed to provide accurate cost data and other information capable of verification by qualified auditors and adequate for cost reporting purposes under section 1815 of the Act, and (2) That no financial arrangements exist that will thwart the commitment of the Medicare program to reimburse providers the reasonable cost of services furnished beneficiaries. The data and information to be examined include cost, revenue, statistical, and other information pertinent to reimbursement including, but not limited to, that described in paragraph (d) of this section and in § 413.24.

(d) *Continuing provider recordkeeping requirements.* (1) The provider must furnish such information to the intermediary as may be necessary to (i) Assure proper payment by the program, including the extent to which there is any common ownership or control (as described in § 413.17(b)(2) and (3)) between providers or other organizations, and as may be needed to identify the parties responsible for submitting program cost reports; (ii) Receive program payments; and (iii) Satisfy program overpayment determinations.

(2) The provider must permit the intermediary to examine such records and documents as are necessary to ascertain information pertinent to the determination of the proper amount of program payments due. These records include, but are not limited to, matters pertaining to—

(i) Provider ownership, organization, and operation;

(ii) Fiscal, medical, and other recordkeeping systems;

(iii) Federal income tax status;

(iv) Asset acquisition, lease, sale, or other action;

(v) Franchise or management arrangements;

(vi) Patient service charge schedules;

(vii) Costs of operation;

(viii) Amounts of income received by source and purpose; and

(ix) Flow of funds and working capital.

(3) The provider, upon request, must furnish the intermediary copies of patient service charge schedules and changes thereto as they are put into effect. The intermediary will evaluate such charge schedules to determine the extent to which they may be used for determining program payment.

(e) *Suspension of program payments to a provider.* If an intermediary determines that a provider does not maintain or no longer maintains adequate records for the determination of reasonable cost under the Medicare program, payments to such provider will be suspended until the intermediary is assured that adequate records are maintained. Before suspending payments to a provider, the intermediary will in accordance with the provisions in § 405.371(a) of this chapter, send written notice to such provider of its intent to suspend payments. The notice will explain the basis for the intermediary's determination with respect to the provider's records and will identify the provide'rs recordkeeping deficiencies. The provider must be given the opportunity, in accordance with § 405.371(a) of this chapter, to submit a statement (including any pertinent evidence) as to why the suspension must not be put into effect.

§ 413.24 Adequate cost data and cost finding.

(a) *Principle.* Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting.

However, if governmental institutions operate on a cash basis of accounting, cost data based on such basis of accounting will be acceptable, subject to appropriate treatment of capital expenditures.

(b) *Definitions*—(1) *Cost finding.* Cost finding is the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services furnished. It is the determination of these costs by the allocation of direct costs and proration of indirect costs.

(2) *Accrual basis of accounting.* Under the accrual basis of accounting, revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

(c) *Adequacy of cost information.* Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization, whether it is operated for profit or on a nonprofit basis. It is a reasonable expectation on the Part of any agency paying for services on a cost-reimbursement basis. In order to provide the required cost data and not impair comparability, financial and statistical records should be maintained in a manner consistent from one period to another. However, a proper regard for

consistency need not preclude a desirable change in accounting procedures if there is reason to effect such change.

(d) *Cost finding methods.* After the close of the accounting period, providers must use one of the following methods of cost finding to determine the actual costs of services furnished during that period. For cost reporting periods beginning after December 31, 1971, providers using departmental method of cost apportionment must use the step-down method described in paragraph (d)(1) of this section or an "other method" described in paragraph (d)(2) of this section. For cost reporting periods beginning after December 31, 1971, providers using the combination method of cost apportionment must use the modified cost finding method described in paragraph (d)(3) of this section. Effective for cost reporting periods beginning on or after October 1, 1980, HHAs not based in hospitals or SNFs must use the step-down method described in paragraph (d)(1) of this section. HHAs based in hospitals or SNFs must use the method applicable to the parent institution.) However, an HHA not based in a hospital or SNF that received less than $35,000 in Medicare reimbursement for the immediately preceding cost reporting period, and for whom this reimbursement represented less than 50 percent of the total operating cost of the agency, may use a simplified version of the step-down method, as specified in instructions for the cost report issued by HCFA.

(1) *Step-down Method.* This method recognizes that services furnished by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue-producing centers as well as by the revenue-producing centers. All costs of nonrevenue-producing centers are allocated to all centers that they serve, regardless of whether or not these centers produce revenue. The costs of the nonrevenue-producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the nonrevenue-producing center, that center will be considered "closed" and no further costs are apportioned to that center. This applies even though it may have received some service from a center whose cost is apportioned later. Generally, if two centers furnish services to an equal number of centers while receiving benefits from an equal number, that center which has the greatest amount of expense should be allocated first.

(2) *Other methods*—(i) *The double-apportionment method.* The double-apportionment method may be used by a provider upon approval of the intermediary. This method also recognizes that the nonrevenue-producing departments or centers furnish services to other nonrevenue-producing centers as well as to revenue-producing centers. A preliminary allocation of the costs of non-revenue-producing centers is made. These centers or departments are not "closed" after this preliminary allocation. Instead, they remain "open," accumulating a portion of the costs of all other centers from which services are received. Thus, after the first or preliminary allocation, some costs will remain in each center representing services received from other centers. The first or preliminary allocation is followed by a second or final apportionment of expenses involving the allocation of all costs remaining in the nonrevenue-producing functions directly to revenue-producing centers.

(ii) *More sophisticated methods.* A more sophisticated method designed to allocate costs more accurately may be used by the provider upon approval of the intermediary. However, having elected to use the double-apportionment method, the provider may not thereafter use the step-down method without approval of the intermediary. Written request for the approval must be made on a prospective basis and must be submitted before the end of the fourth month of the prospective reporting period. Likewise, once having elected to use a more sophisticated method, the provider may not thereafter use either the double-apportionment or step-down methods without similar request and approval.

(3) *Modified cost finding for providers using the Combination Method for reporting periods beginning after December 31, 1971.* This method differs from the step-down method in that services furnished by nonrevenue-producing departments or centers are allocated directly to revenue-producing departments or centers even though these services may be utilized by other nonrevenue-producing departments or centers. In the application of this method the cost of nonrevenue-producing centers having a common basis of allocation are combined and the total distributed to revenue producing centers. All nonrevenue-producing centers having significant percentages of cost in relation to total costs will be allocated this way. The combined total costs of remaining nonrevenue-producing costs centers will be allocated to revenue-producing cost centers in the proportion that each bears to total costs, direct and indirect, already allocated. The bases which are to be used and the centers which are to be combined for allocation are not optional but are identified and incorporated in the cost report forms developed for this method. Providers using this method must use the program cost report forms devised for it. Alternative forms may not be used without prior approval by HCFA based upon a written request by the provider submitted through the intermediary.

(4) *Temporary method for initial period.* If the provider is unable to use either cost-finding method when it first participates in the program, it may apply to the intermediary for permission to use some other acceptable method that would accurately identify costs by department or center, and appropriately segregate inpatient and outpatient costs. Such other method may be used for cost reports covering periods ending before January 1, 1968.

(5) *Simplified optional reimbursement method for small, rural hospitals with distinct parts for cost reporting periods beginning on or after July 20, 1982.* (i) A rural hospital with a Medicare-certified distinct part SNF may elect to be reimbursed for services furnished in its hospital general routine service area and distinct part SNF using the reimbursement method specified in § 413.53 for swing-bed hospitals if it meets the following conditions: (A) The institution is located in a rural area as defined in § 482.66 of this chapter. (B) On the first day of the cost reporting period, the hospital and distinct part SNF have fewer than 50 beds in total (with the exception of beds for newborns and beds in intensive care type inpatient units).

(ii) In applying the optional reimbursement method, only those beds located in the hospital general routine service area and in the distinct part SNF certified by Medicare are combined into a single cost center for purposes of cost finding.

(iii) The reasonable cost of the routine extended care services is determined in accordance with § 413.114(c). The reasonable cost of the hospital general routine services is determined in accordance with § 413.53(a)(2).

(iv) The hospital must make its election to use the optional swing-bed reimbursement method in writing to the intermediary before the beginning of the hospital's cost reporting year. The hospital must make any request to revoke the election in writing before the

beginning of the affected cost reporting period.

(v) The intermediary must approve requests to terminate use of the optional swing-bed reimbursement method. If a hospital terminates use of this optional method, no further elections may be made by the facility to use the optional method.

(e) *Accounting basis.* The cost data submitted must be based on the accrual basis of accounting which is recognized as the most accurate basis for determining costs. However, governmental institutions that operate on a cash basis of accounting may submit cost data on the cash basis subject to appropriate treatment of capital expenditures.

(f) *Cost reports.* For cost reporting purposes, the Medicare program requires each provider of services to submit periodic reports of its operations that generally cover a consecutive 12-month period of the provider's operations. Amended cost reports to revise cost report information that has been previously submitted by a provider may be permitted or required as determined by HCFA.

(1) *Cost reports—Terminated providers and changes of ownership.* A provider that voluntarily or involuntarily ceases to participate in the Medicare program or experiences a change of ownership must file a cost report for that period under the program beginning with the first day not included in a previous cost reporting period and ending with the effective date of termination of its provider agreement or change of ownership.

(2) *Due dates for cost reports.* (i) Cost reports are due on or before the last day of the third month following the close of the period covered by the report.

(ii) A 30-day extension of the due date of a cost report may, for good cause, be granted by the intermediary, after first obtaining the approval of HCFA.

(iii) The cost report from a provider that voluntarily or involuntarily ceases to participate in the Medicare program or experiences a change of ownership is due no later than 45 days following the effective date of the termination of the provider agreement or change of ownership.

(3) *Changes in cost reporting periods.* A provider may change its cost reporting period if a change in ownership is experienced or if the—

(i) Provider requests the change in writing from its intermediary;

(ii) Intermediary receives the request at least 120 days before the close of the new reporting period requested by the provider; and

(iii) Intermediary determines that good cause for the change exists. Good cause would not be found to exist if the effect is to change the initial date that a hospital would be affected by the rate of increase ceiling (see § 413.40), or be paid under the prospective payment system (see Part 412 of this chapter).

(g) *Exception from full cost reporting for lack of program utilization.* If a provider does not furnish any covered services to Medicare beneficiaries during a cost reporting period, it is not required to submit a full cost report. It must, however, submit an abbreviated cost report, as prescribed by HCFA.

(h) *Waiver of full cost reporting for low program utilization.* (1) If the provider has had low utilization of covered services by Medicare beneficiaries (as determined by the intermediary) and has received correspondingly low interim reimbursement payments for the cost reporting period, the intermediary may waive a full cost report if it decides that it can determine, without a full report, the reasonable cost of covered services provided during that period.

(2) If a full cost report is waived, the provider must submit within the same time period required for full cost reports:

(i) The cost reporting forms prescribed by HCFA for this situation; and

(ii) Any other financial and statistical data the intermediary requires.

Subpart C—Limits on Cost Reimbursement

§ 413.30 Limitations on reimbursable costs.

(a) *Introduction*—(1) *Scope.* This section implements section 1861(v)(1)(A) of the Act, by setting forth the general rules under which HCFA may establish limits on provider costs recognized as reasonable in determining Medicare program payments, and sections 1861(v)(7)(B) and 1886(a) of the Act, by setting forth the general rules under which HCFA may establish limits on the operating costs of inpatient hospital services that are recognized as reasonable in determining Medicare program payments. (For cost reporting periods beginning on or after October 1, 1983, the operating costs incurred in furnishing inpatient hospital services are not subject to the provisions of this section.) This section also sets forth rules governing exemptions, exceptions, and adjustments to limits established under this section that HCFA may make as appropriate in consideration of special needs or situations of particular providers.

(2) *General principle.* Reimbursable provider costs may not exceed the costs estimated by HCFA to be necessary for the efficient delivery of needed health services. HCFA may establish estimated cost limits for direct or indirect overall costs or for costs of specific items or services or groups of items or services. These limits will be imposed prospectively and may be calculated on a per admission, per discharge, per diem, per visit, or other basis.

(b) *Procedure for establishing limits.* (1) In establishing limits under this section, HCFA may classify providers by type of provider (for example, hospitals, SNFs, and HHAs) and by other factors HCFA finds appropriate and practical, including—

(i) Type of services furnished;

(ii) Geographical area where services are furnished, allowing for grouping of noncontiguous areas having similar demographic an economic characteristics;

(iii) Size of institution;

(iv) Nature and mix of services furnished; or

(v) Type and mix of patients treated.

(2) Estimates of the costs necessary for efficient delivery of health services may be based on cost reports or other data providing indicators of current costs. Current and past period data will be adjusted to arrive at estimated costs for the prospective periods to which limits are being applied.

(3) Prior to the beginning of a cost period to which revised limits will be applied, HCFA will publish a notice in the **Federal Register**, establishing cost limits and explaining the basis on which they were calculated.

(4) In establishing limits under paragraph (b)(1) of this section, HCFA may find it inappropriate to apply particular limits to a class of providers due to the characteristics of the provider class, the data on which those limits are based, or the method by which the limits are determined. In such cases, HCFA may exclude that class of providers from the limits, explaining the bases of the exclusion in the notice setting forth the limits for the appropriate cost reporting periods.

(c) *Provider requests regarding applicability of cost limits.* A provider may request a reclassification, exception, or exemption from the cost limits imposed under this section. The provider's request must be made to its fiscal intermediary within 180 days of the date on the intermediary's notice of program reimbursement. The intermediary will make a recommendation on the provider's request to HCFA, which will make the decision. HCFA will respond to the exception request within 180 days from

the date HCFA receives the request from the intermediary. The intermediary will notify the provider of HCFA's decision. The time required for HCFA to review the exception request will be considered good cause for the granting of an extension of the time limit to apply for a Board review, as specified in § 405.1841 of this chapter. HCFA's decision is subject to review under Subpart R of Part 405 of this chapter.

(d) *Reclassification.* A provider may obtain a reclassification if it can show that its classification is at variance with the criteria specified in promulgating the limits.

(e) *Exemptions.* Exemptions from the limits imposed under this section may be granted in the following circumstances:

(1) *Sole community hospital.* A sole community hospital is a hospital which, by reason of factors such as isolated location or absence of other hospitals, is the sole source of such care reasonably available to beneficiaries.

(2) *New provider.* The provider of inpatient services has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years. An exemption granted under this paragraph expires at the end of the provider's first cost reporting period beginning at least two years after the provider accepts its first patient.

(3) *Risk-basis HMO.* The items or services are furnished to beneficiaries enrolled in an HMO by a provider that is either owned or operated by a risk-basis HMO or related to a risk-basis HMO by common ownership or control (see § 417.250(c)).

(4) *Rural hospital with less than 50 beds.* The hospital—

(i) Was in operation with less than 50 beds as of September 3, 1982;

(ii) Has less than 50 beds throughout the applicable cost reporting period; and

(iii) Is outside the boundaries of all Standard Metropolitan Statistical Areas as designated by the Executive Office of Management and Budget.

(f) *Exceptions.* Limits established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(1) through (f)(8) of this section, and may be adjusted upward or downward under the circumstances specified in paragraph (f)(9) of this section. An adjustment is made only to the extent the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary.

(1) *Atypical services.* The provider can show that the—

(i) Actual cost of items or services furnished by a provider exceeds the applicable limit because such items or services are atypical in nature and scope, compared to the items or services generally furnished by providers similarly classified; and

(ii) Atypical items or services are furnished because of the special needs of the patients treated and are necessary in the efficient delivery of needed health care.

(2) *Extraordinary circumstances.* The provider can show that it incurred higher costs due to extraordinary circumstances beyond its control. These circumstances include, but are not limited to, strikes, fire, earthquake, flood, or similar unusual occurrences with substantial cost effects.

(3) *Providers in areas with fluctuating populations.* (i) The provider is located in an area (for example, a resort area) that has a population that varies significantly during the year;

(ii) The appropriate health planning agency has determined that the area does not have a surplus of beds and similar services and has certified that the beds and services made available by the provider are necessary; and

(iii) The provider meets occupancy standards established by the Secretary.

(4) *Medical and Paramedical education.* The provider can demonstrate that, if compared to other providers in its group, it incurs increased costs for items or services covered by limits under this section because of its operation of an approved education program specified in § 413.85.

(5) *More intensive routine care for cost reporting periods beginning before October 1, 1982.* The hospital—

(i) Is subject to per diem limits on inpatient general routine operating costs issued under paragraph (b)(3) of this section;

(ii) Furnishes a greater intensity of inpatient general routine operating care than other hospitals having a reasonably similar mix of patients; and

(iii) Shows that the more intensive care results in a shorter average length of stay and higher per unit costs than in comparable hospitals.

(6) *Essential community hospital services exception.* The Secretary finds that—

(i) The hospital exceeds its applicable limit by more than 15 percent;

(ii) Full application of the limits would render the hospital insolvent;

(ii) Such insolvency would deprive the community of essential services; and

(iv) The hospital has taken, or provided adequate assurances that it plans to take, all available efficiency and economy measures to bring its costs into line with those of comparable facilities. In this case, the Secretary may grant an exception to the limit for the amount by which the hospital exceeds 115 percent of its applicable limit for such period as he deems necessary (but not to exceed the period during which the hospital meets the enumerated conditions).

(7) *Newly-established HHA.* The agency can demonstrate that—

(i) It has provided under present and previous ownship for a period of less than three full years home health care services equivalent to those that would have been covered if the agency had a Medicare provider agreement in effect. Eligibility for an exception under this paragraph ceases with the end of the cost reporting period that begins not more than 24 months after the HHA makes its first visit covered under the Medicare program or its first visit that would have been covered under the Medicare program if the agency had a Medicare provider agreement in effect.

Example No. 1: HHA A had been operating for several years and had been performing only "homemaker" visits. The Medicare provider agreement of HHA A became effective on July 1, 1980 and on that date the agency performed its first skilled nursing visit. HHA A's first cost reporting period under Medicare ends December 31, 1980. HHA A qualifies under this paragraph for an exception for the periods ending December 31, 1980, December 31, 1981, and December 31, 1982 because the first Medicare covered visit was performed on July 1, 1980. Prior in that date, the agency only provided "homemaker" visits (not covered by Medicare).

Example No. 2: HHA B began operating on January 1, 1974, providing only homemaker visits. In July 1974, it contracted with an HHA participating in the Medicare program to supply staff that HHA B used to furnish nursing and home health aide visits in addition to homemaker services. HHA B obtained a Medicare provider agreement effective on March 1, 1980, and its first cost reporting period under Medicare ended February 28, 1981. HHA B may not qualify under this paragraph as a newly-established HHA because it has been furnishing skilled nursing and home health aide visits (of the type reimbursable by Medicare) under contract since July 1974 (first visit).

(ii) Its variable operating cost were reasonable in relation to its utilization during the year; and

(iii) Its fixed operating costs are reasonable in relation to realistic projection of utilization to be achieved at the end of the provider's second full year (the reporting year containing the 24th month after the start of the provider's first cost reporting period) of operation in the program.

(8) *Unusual labor costs.* The provider has a percentage of labor costs that varies more than 10 percent from that included in the promulgation of the limits.

(9) *Changes in case mix for cost reporting periods beginning before October 1, 1983.* The hospital—

(i) Is subject to limits issued under paragraph (b)(3) of this section for cost reporting periods beginning before October 1, 1983, that are calculated by use of a case-mix index;

(ii) Has added or discontinued services in a year after the year represented in the discharge data used to establish the limits described in paragraph (f)(9)(i) of this section;

(iii) Has experienced a significant and abrupt change in case mix as a result of the addition or deletion of services; and

(iv) Submits discharge data, in the format required by HCFA, for Medicare discharges in the cost reporting period for which the exception is requested.

(g) *Operational review of providers receiving an exception.* Any provider that applies for an exception to the limits established under paragraph (f) of this section must agree to an operational review at the discretion of HCFA. The findings from any such review may be the basis for recommendations for improvements in the efficiency and economy of the provider's operations. If such recommendations are made, any future exceptions shall be contingent on the provider's implementation of these recommendations.

(h) *Adjustments.* For cost reporting periods beginning on or after October 1, 1982 and before October 1, 1983, HCFA may adjust the amount of a hospital's inpatient operating costs to take into account factors that could result in a significant distortion in the operating costs of inpatient hospital services. Such factors could include a decrease in the inpatient services that a hospital provides that are customarily provided directly by similar hospitals, or the manipulation of discharges to increase reimbursement. A decrease in inpatient services could result from changes that include, but are not limited to, such actions as closing a special care unit or changing the arrangements under which such services may be furnished, such as leasing a department.

§ 413.35 Limitations on coverage of costs: Charges to beneficiaries if cost limits are applied to services.

(a) *Principle.* A provider of services that customarily furnishes an individual items or services that are more expensive than the items or services determined to be necessary in the efficient delivery of needed health services described in § 413.30, may charge an individual entitled to benefits under Medicare for such more expensive items or services even though not requested by the individual. The charge, however, may not exceed the amount by which the cost of (or, if less, the customary charges for) such more expensive items or services furnished by such provider in the second cost reporting period immediately preceding the cost reporting period in which such charges are imposed exceeds the applicable limit imposed under the provisions of § 413.30. This charge may be made only if—

(1) The intermediary determines that the charges have been calculated properly in accordance with the provisions of this section;

(2) The services are not emergency services as defined in paragraph (d) of this section;

(3) The admitting physician has no direct or indirect financial interest in such provider;

(4) HCFA has provided notice to the public through notice in a newspaper of general circulation servicing the provider's locality and such other notice as the Secretary may require, of any charges the provider is authorized to impose on individuals entitled to benefits under Medicare on account of costs in excess of the costs determined to be necessary in the efficient delivery of needed health services under Medicare; and

(5) The provider has, in the manner described in paragraph (e) of this section, identified such charges to such individual or person acting on his behalf as charges to meet the costs in excess of the costs determined to be necessary in the efficient delivery of needed health services under Medicare.

(b) *Provider request to charge beneficiaries for costs in excess of limits.* (1) If a provider's actual costs (or, if less, the customary charges) in the second preceding cost period exceed the prospective limits established for such costs, the intermediary will, at the provider's request, validate in advance the charges that may be made to the beneficiaries for the excess.

(2) If a provider does not have a second preceding cost period and is a new provider as defined in § 413.30(e)(2) the provider, subject to validation by the intermediary, will estimate the currrent cost of the service to which a limit is being applied. Such amount will be adjusted to an amount equivalent to costs in the second preceding year by use of a factor to be developed based on estimates of cost increases during the preceding two years and published by SSA or HCFA. The amount thus derived will be used in lieu of the second preceding cost period amount in determining the charge to the beneficiary.

(3) To obtain consideration of such a request, the provider must submit to the intermediary a statement indicating the chagre for which it is seeking validation and providing the data and method used to determine the amount. Such statement should include the—

(i) Provider's name and number;

(ii) Identity of class and prospective cost limit for the class in which the provider has been included;

(iii) Amount of charge and cost period in which the charge is to be imposed;

(iv) Cost and customary charge for items and services furnished to beneficiaries; and

(v) Cost period ending date of the second reporting period immediately preceding the cost period in which the charge is to be imposed. The intermediary may request such additional information as it finds necessary with respect to the request.

(c) *Provider charges—(1) Establishing the charges.* If the actual cost incurred (or, if less, the customary charges) in the prior period determined under paragraph (a) of this section exceeds the limits applicable to the pertinent period, the provider may charge the beneficiary to the extent costs in the second preceding cost reporting period (or the equivalent when there is no second preceding period) exceed the current cost limits. (Data from the most recently submitted appropriate cost report will be used in determining the actual cost.) For example, if a limit of $58 per day is applied to the cost of general routine services for the provider's cost reporting period starting in calendar year 1975 and if the provider's actual general routine cost in the second preceding reporting period, that is, the reporting period starting in calendar year 1973, was $60 per day, the provider (after first having obtained intermediary validation and subject to the considerations and requirements specified in paragraph (a) of this section) may charge Medicare Part A beneficiaries up to $2 per day for general routine services.

(2) *Adjusting cost.* Program reimbursement for the costs to which limits imposed under § 413.30 are applied in any cost reporting period will not exceed the lesser of the provider's actual cost or the limits imposed under § 413.30. If program reimbursement for items or services to which such limits are applied plus the charges to beneficiaries for such items or services imposed under this section exceed the provider's actual cost for such items or

services, program payment to the provider will be reduced to the extent program payment plus charges to the beneficiaries exceed actual cost. If the provider's actual cost for general routine services in 1975 was $57,000, the cost limit was $58,000, and billed charges to Medicare Part A beneficiaries were $2,000, the provider would receive $55,000 from the program ($57,000 actual cost minus the $2,000 in charges to the beneficiaries).

(d) *Definition of emergency services.* For purposes of paragraph (a)(2) of this section, emergency services are those hospital services that are necessary to prevent the death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital (see § 405.192 of this chapter) available and equipped to furnish such services. If an individual has been admitted to such hospital as an inpatient because of an emergency, the emergency will be deemed to continue until it is safe from a medical standpoint to move the individual to another hospital or other institution or to discharge him.

(e) *Identification of charges to individual.* For purposes of paragraph (a)(5) of this section, a provider must give or send to the individual or his representative, a schedule of all items and services that the individual might need and for which the provider imposes charges under this section, and the charge for each. Such schedule must specify that the charges are necessary to meet the costs in excess of the costs determined to be necessary in the efficient delivery of needed health services under Medicare and include such other information as the HCFA considers necessary to protect the individual's rights under this section. The provider, in arranging for the individual's admission, first service, or start of care, must give or send this schedule to the individual or his representative when arrangements are being made for such services or if this is not feasible, as soon thereafter as is practicable but no later than at the initiation of services.

§ 413.40 Ceiling on rate of hospital cost increases.

(a) *Introduction*—(1) *Scope.* This section implements section 1886(b) of the Act establishing a ceiling on the rate of increase of operating costs per case for inpatient hospital services that will be recognized as reasonable for purposes of determining Medicare reimbursement. This ceiling on allowable rate of cost increases applies to hospital cost reporting periods beginning on or after October 1, 1982 and, for cost reporting periods beginning before October 1, 1983, is applied in addition to the limitations on reasonable cost established under § 413.30. This section also sets forth rules governing exemptions from, and exceptions and adjustments to, the ceiling.

(2) *Applicability.* (i) This section is not applicable to hospitals reimbursed in accordance with section 1814(b)(3) of the Act, or under State reimbursement control systems that have been approved under section 1886(c) of the Act.

(ii) For cost reporting periods beginning on or after October 1, 1983, this section is applicable to hospitals excluded from the prospective payment system under Subpart B of Part 412 of this chapter, including subprovider psychiatric and rehabilitation units (distinct parts) and those hospitals eligible for special treatment under the prospective payment system as described in § 412.94(b) of this chapter.

(b) *Cost reporting periods subject to the rate of increase ceiling*—(1) *Base period.* Each hospital's initial ceiling will be based on allowable inpatient operating costs per case incurred in the 12-month cost reporting period immediately preceding the first cost reporting period subject to ceilings established under this section, except that, when the immediately preceding cost reporting period is a short reporting period (fewer than 12 months) the first 12-month period beginning on or after the date the hospital's exemption from the ceiling ends will be the base period.

(2) *Periods subject to the ceiling.* Ceilings established under this section will be applied to all full 12-month cost reporting periods that—

(i) Immediately follow either a base period as described in paragraph (b)(1) of this section, or another 12-month cost reporting period subject to the ceiling; and

(ii) Begin on or after October 1, 1982.

(3) *Periods other than 12 months.* Ceilings established under this section will not apply to cost reporting periods of fewer than 12 months that occur along with a change in operations of the facility as a result of changes in ownership, merger, or consolidation. However, ceilings will apply to cost reporting periods of fewer than 12 months that result solely from the approval of a hospital's request for a change in accounting cycle. In the case of such periods, the applicable percentage rate of increase will be adjusted downward by a monthly factor corresponding to the annual percentage rate to reflect fewer months. Ceilings established under this section will apply to cost reporting periods of greater than 12 months with the percentage rate of increase adjusted upward by a monthly factor corresponding to the annual percentage rate to reflect the additional months.

(c) *Procedure for establishing the ceiling (target amount)—(1) Costs subject to the ceiling.* (i) The cost per case ceiling established under this section applies to operating costs incurred by a hospital in furnishing inpatient hospital services.

(ii) For cost reporting periods beginning on or after October 1, 1983, these operating costs *include* operating costs of routine services (as described in § 405.158(c) of this chapter), ancillary service operating costs, and special care unit operating costs. These operating costs *exclude* the costs of malpractice insurance, certain kidney acquisition costs, capital-related costs, and costs a hospital allocates to approved medical education programs (nursing school or approved intern and resident programs) on its Medicare cost report.

(iii) For cost reporting periods beginning on or after October 1, 1983, these operating costs exclude only capital-related costs as described in § 413.130, return on equity capital as described in § 413.157, and the costs of approved medical education programs as described in § 413.85. Further, kidney acquisition costs incurred by hospitals approved as renal transplantation centers will be reimbursed on a reasonable cost basis. Appropriate adjustment to a hospital's base year costs will be made under paragraph (h) of this section.

(2) *Cost determined on a per case basis.* Costs subject to the ceiling as described in paragraph (c)(1) of this section will be determined on a per discharge basis.

(3) *Target rate percentage.* (i) The applicable target rate percentage is determined as follows:

(A) *Federal fiscal year 1986.* The applicable target rate percentage for cost reporting periods beginning on or after October 1, 1985 and before September 30, 1986 is five-twenty-fourths of one percent. For purposes of determining the target amount for cost reporting periods beginning on or after October 1, 1986, the applicable percentage increase with respect to cost reporting periods beginning during Federal fiscal year 1986 is deemed to have been one-half percent.

(B) *Federal fiscal years 1987 and following.* Subject to the limitation set forth in paragraph (c)(3)(i)(C) of this section, the applicable target rate

percentage for cost reporting periods beginning during fiscal year 1987 and in all fiscal years thereafter is determined using the methodology set forth in § 412.63 (e)(1) through (e)(3) of this chapter.

(c) *Limitation for Federal fiscal years 1987 and 1988.* For cost reporting periods beginning in fiscal years 1987 and 1988, the applicable percentage determined under paragraph (c)(3)(i)(B) of this section is not to exceed the prospectively estimated increase in the market basket index for the cost reporting period.

(ii) The market basket index is a hospital wage and price index that incorporates appropriately weighted indicators of changes in wages and prices that are representative of the mix of goods and services included in the most common categories of inpatient hospital operating costs subject to the ceiling as described in paragraph (c)(1) of this section.

(4) *Target amount (ceiling).* The intermediary will establish for each hospital a ceiling on the reimbursable costs per case of that hospital. The ceiling for each 12-month cost reporting period will be set at a target amount determined as follows:

(i) For the first 12-month cost reporting period to which this ceiling applies, the target amount will equal the hospital's allowable operating costs per case for the hospital's base period increased by the target rate percentage for the subject period.

(ii) For subsequent 12-month cost reporting periods, the target amount will equal the hospital's target amount for the previous 12-month cost reporting period increased by the target rate percentage for the subject cost reporting period.

(5) *Applicable target rate percentage.* (1) The intermediary will use the target rate percentage increase applicable to each 12-month cost reporting period to determine the ceiling on the allowable rate of cost increase under this section.

(ii) When a cost reporting period spans portions of two calendar years, the intermediary will calculate an appropriate prorated percentage rate based on the published calendar year percentage rates.

(iii) The applicable target rate percentage will be the prospectively determined percentage published by HCFA. The percentages will be applied prospectively and will be prorated in accordance with paragraph (c)(5)(ii) of this section, but will not be retroactively adjusted if the acutal market basket rate of increase differs from the estimate.

(d) *Application of target amounts in determining reimbursement*—(1) *General process.* (i) At the end of each 12-month cost reporting period subject to this section, the hospital's intermediary will compare a hospital's allowable cost per case with that hospital's target amount for that period.

(ii) The hospital's actual allowable costs will be determined without regard to the lesser of cost or charges provisions of § 413.13, but, for cost reporting periods beginning on or after October 1, 1982 and before October 1, 1983, are subject to other limitations on reimbursable cost established under § 413.30.

(iii) If the hospital's actual allowable costs do not exceed the target amount, reimbursement will be determined under paragraph (d)(2) of this section.

(iv) If the hospital's actual costs exceed the target amount, reimbursement will be determined under paragraph (d)(3) of this section.

(2) *Inpatient operating costs are less than or equal to the target amount.* If a hospital's allowable inpatient operating costs per case do not exceed the hospital's target amount for the applicable cost reporting period, reimbursement to the hospital will be determined on the basis of the lowest of the—

(i) Inpatient operating costs per case plus 50 percent of the difference between the inpatient operating cost per case and the target amount;

(ii) Inpatient operating costs per case plus 5 percent of the target amount; or

(iii) Hospital's allowable inpatient operating cost per case under applicable limits established under § 413.30, if applicable.

(3) *Inpatient operating costs are greater than the target amount.* If a hospital's allowable inpatient operating costs per case exceed the hospital's target amount for the applicable cost reporting period. Reimbursement to the hospital will be determined as follows:

(i) For cost reporting periods beginning on or after October 1, 1982 and before October 1, 1984, reimbursement will be based on the lower the of hospital's—

(A) Target amount plus 25 percent of the allowable operating costs per case in excess of the target amount; or

(B) Allowable cost per case under applicable limits established under § 413.30 if applicable.

(ii) For cost reporting periods beginning on or after October 1, 1984, reimbursement will be based on the hospital's target amount per case.

(e) *Hospital requests regarding applicability of the rate of increase ceiling.* A hospital may request an exemption from, or exception to, the rate of cost increase ceiling imposed under this section. The hospital's request must be made to its fiscal intermediary no later than 180 days from the date on the intermediary's notice of program reimbursements. The intermediary will make a recommendation on the hospital's request to HCFA, which will make the decision. HCFA will respond to the exception request within 180 days from the date HCFA receives the request from the intermediary. The intermediary will notify the hospital of HCFA's decision. The time required for HCFA to review the exception request is considered good cause for the granting of an extension of the time limit to apply for review by the Provider Reimbursement Review Board, as specified in § 405.1841(b) of this chapter. HCFA's decision is subject to review under Subpart R of Part 405 of this chapter.

(f) *Exemptions*—(1) *New hospitals.* New hospitals that request and receive an exemption from HCFA are not subject to the rate of increase ceiling imposed under this section. For purposes of this section, a new hospital is a provider of inpatient hospital services that has operated as the type of hospital for which HCFA granted it approval to participate in the Medicare program, under present or previous ownership, or both, for less than three full years. This exemption expires at the end of the first cost reporting period beginning at least two years after the hospital accepts its first patient.

(2) *Risk-basis HMO.* The items or services are furnished to beneficiaries enrolled in an HMO by a hospital that is either owned or operated by a risk-basis HMO or related to a risk-basis HMO by common ownership or control (see § 417.250(c)).

(g) *Exceptions*—(1) *General procedure.* HCFA may adjust a hospital's operating costs (as described in paragraph (b)(1) of this section) upward or downward, as appropriate, under circumstances as specified in paragraphs (g) (2) and (3) of this section. HCFA will make an adjustment only to the extent that the hospital's operating costs are reasonable, attributable to the circumstances specified, separately identified by the hospital, and verified by the intermediary.

(2) *Extraodinary circumstances.* The hospital can show that it incurred unusual costs (in either a cost reporting period subject to the ceiling or the hospital's base period) due to extraordinary circumstances beyond its control. These circumstances include, but are not limited to, strikes, fire, earthquakes, floods, or similar unusual

occurrences with substantial cost effects.

(3) *Change in case mix.* The hospital—

(i) Has added or discontinued services in a year after its base period described in paragraph (b)(1) of this section;

(ii) Has experienced a change in case mix as a result of the addition or discontinuation of services that results in a distortion in the rate of cost increase; and

(iii) Submits data summarizing the case-mix changes and the resulting changes in costs.

(h) *Adjustments*—(1) *Comparability of cost reporting periods.* (i) HCFA may adjust the amount of the operating costs considered in establishing cost per case for one or more cost reporting periods, including both periods subject to the ceiling and the hospital's base period, to take into account factors that could result in a significant distortion in the operating costs of inpatient hospital services. The adjustments include, but are not limited to, adjustments of the base period costs to include explicitly FICA taxes (if the hospital did not incur costs for FICA taxes in its base period), and services billed under Part B of Medicare during the base period, but paid under Part A during the subject cost reporting period.

(ii) In determining the target amount for cost reporting periods beginning on or after October 1, 1983, the intermediary will adjust the base period costs to explicitly include in the costs subject to the ceiling malpractice insurance costs.

(iii) HCFA may adjust the amount of operating costs, under paragraph (c)(1) of this section, to take into account factors such as a change in the inpatient hospital services that a hospital provides, that are customarily provided directly by similar hospitals, or the manipulation of discharges to increase reimbursement. A change in the inpatient hospital services provided could result from changes that include, but are not limited to, opening or closing a special care unit or changing the arrangements under which such services may be furnished, such as leasing a department.

(2) *Nursing differential.* Because the Medicare inpatient routine nursing salary cost differential does not apply in the cost reporting periods subject to ceilings established under this section, HCFA will adjust base period costs to remove the effect of this differential.

Subpart D—Apportionment

§ 413.50 Apportionment of allowable costs.

(a) Consistent with prevailing practice in which third-party organizations pay for health care on a cost basis, reimbursement under the Medicare program involves a determination of—(1) Each provider's allowable costs; for producing services, and (2) The share of these costs which is to be borne by Medicare, the provider's costs are to be determined in accordance with the principles reviewed in the preceding discussion relating to allowable costs the share to be borne by Medicare is to be determined in accordance with principles relating to apportionment of cost.

(b) In the study and consideration devoted to the method of apportioning cost, the objective has been to adopt methods for use under Medicare that would, to the extent reasonably possible, result in the program's share of a provider's total allowable costs being the same as the program's share of the provider's total services. This result is essential for carrying out the statutory directive that the program's payments to providers should be such that the costs of covered services for beneficiaries would not be passed on to nonbeneficiaries, nor would the cost of services for nonbeneficiaries be borne by the program.

(c) A basic factor bearing upon apportionment of costs is that Medicare beneficiaries are not a cross section of the total population. Nor will they constitute a cross section of all patients receiving services from most of the providers that participate in the program. Available evidence shows that the use of services by persons age 65 and over differs significantly from other groups. Consequently, the objective sought in the determination of the Medicare share of a provider's total costs means that the methods used for apportionment must take into account the differences in the amount of services received by patients who are beneficiaries and other patients serviced by the provider.

(d) The method of cost reimbursement most widely used at the present time by third-party purchasers of inpatient hospital care apportions a provider's total costs among groups served on the basis of the relative number of days of care used. This method, commonly referred to as average-per-diem cost, does not take into account, variations in the amount of service which a day of care may represent and thereby assumes that the patients for whom payment is made on this basis are average in their use of service.

(e) In considering the average-per-diem method of apportioning cost for use under the program, the difficulty encountered is that the preponderance of presently available evidence strongly indicates that the over-age 65 patient is not typical from the standpoint of average-per-diem cost. On the average this patient stays in the hospital twice as long and therefore the ancillary services that he uses are averaged over the longer period of time, resulting in an average per diem cost for the aged alone, significantly below the average per diem for all patients.

(f) Moreover, the relative use of services by aged patients as compared to other patients differs significantly among institutions. Consequently, considerations of equity among institutions are involved as well as that of effectiveness of the apportionment method under the program in accomplishing the objective of paying each provider fully, but only for services to beneficiaries.

(g) A further consideration of long-range importance is that the relative use of services by aged an other patients can be expected to change, possibly to a significant extent in future years. The ability of apportionment methods used under the program to reflect such change is an element of flexibility which has been regarded as important in the formulation of the cost reimbursement principles.

(h) An alternative to the relative number of days of care as a basis for apportioning costs is the relative amount of charges billed by the provider for services to patients. The amount of charges is the basis upon which the cost of hospital care is distributed among patients who pay directly for the services they receive. Payment for services on the basis of charges applies generally under insurance programs in which individuals are indemnified for incurred expenses, a form of health insurance widely held throughout the United States. Also, charges to patients are commonly a factor in determining the amount of payment to hospitals under insurance programs providing service benefits, many of which pay "costs or charges, whichever is less" and some of which pay exclusively on the basis of charges. In all of these instances, the provider's own charge structure and method of itemizing services for the purpose of assessing charges is utilized as a measure of the amount of services received and as the basis for allocating responsibility for

payment among those receiving the provider's services.

(i) An increasing number of third-party purchasers who pay for services on the basis of cost are developing methods that utilize charges to measure the amount of services for which they have responsibility for payment. In this approach, the amount of charges for such services as a proportion of the provider's total charges to all patients is used to determine the proportion of the provider's total costs for which the third-party purchaser assumes responsibility. The approach is subject to numerous variations. It can be applied to the total of charges for all services combined or it can be applied to components of the provider's activities for which the amount of costs and charges are ascertained through a breakdown of data from the provider's accounting records.

(j) For the application of the approach to components, which represent types of services, the breakdown of total costs is accomplished by "cost-finding" techniques under which indirect costs and nonrevenue activities are allocated to revenue producing components for which charges are made as services are furnished.

§ 413.53 Determination of cost of services to beneficiaries.

(a) *Principle.* Total allowable costs of a provider will be apportioned between program beneficiaries and other patients so that the share borne by the program is based upon actual services received by program beneficiaries. The methods of apportionment are defined as follows:

(1) *Departmental method*—(i) *Methodology.* Except as provided in § 413.56 with respect to the direct apportionment of malpractice costs, and in paragraph (a)(1)(ii) of this section with respect to the treatment of the private room cost differential for cost reporting periods starting on or after October 1, 1982, the ratio of beneficiary charges to total patient charges for the services of each ancillary department is applied to the cost of the department; to this is added the cost of routine services for program beneficiaries, determined on the basis of a separate average cost per diem for general routine patient care areas as defined in paragraph (b) of this section, taking into account, in hospitals, a separate average cost per diem for each intensive care unit, coronary care unit, and other intensive care type inpatient hospital units.

(ii) *Exception: Indirect cost of private rooms.* For cost reporting periods starting on or after October 1, 1982, except with respect to a hospital receiving payment under Part 412 of this chapter, the additional cost of furnishing services in private room accommodations is apportioned to Medicare only if these accommodations are furnished to program beneficiaries, and are medically necessary. To determine routine service cost applicable to beneficiaries—

(A) Multiply the average cost per diem (as defined in paragraph (b) of this section) by the total number of Medicare patient days (including private room days whether or not medically necessary);

(B) Add the product of the average per diem private room cost differential (as defined in paragraph (b) of this section) and the number of medically necessary private room days used by beneficiaries; and

(C) Do not include private rooms furnished for SNF-type and ICF-type services under the swing-bed provision in the number of days in paragraphs (a)(1)(ii) (A) and (B) of this section.

(2) *Carve out method.* (i) The carve out method is used to allocate hospital inpatient general routine service costs in a participating swing-bed hospital, as defined in § 413.114(b). Under this method, the total costs attributable to the SNF-type and ICF-type services furnished to all classes of patients are subtracted from total general routine inpatient service costs before computing the average cost per diem for general routine hospital care.

(ii) The cost per diem attributable to the routine SNF-type services furnished by a swing-bed hospital is based on the reasonable cost per diem for services determined in accordance with § 413.114.

(iii) The cost per diem attributable to the routine ICF services furnished by the swing-bed hospital is determined as follows:

(A) If the hospital is located in a State that provides for ICF services under Medicaid, the cost per diem for ICF services furnished by a swing-bed hospital in that State is based on the Statewide average rate paid for routine services in ICFs (other than ICFs for the mentally retarded) during the preceding calendar year under the State Medicaid plan. The Statewide average rate will be computed either by the State and furnished to HCFA, or by HCFA directly based on the best available data.

(B) If the hospital is located in a State that does not provide for ICF services under Medicaid or that does not have a Medicaid program, the cost per diem for ICF services will be based on the average ratio of the ICF rate to the SNF rate in those States that provide for both SNF and ICF services under Medicaid. The ratio will be applied to the SNF cost per diem determined under paragraph (a)(2)(ii) of this section.

(iv) The sum of total SNF-type days furnished to all classes of patients multiplied by the SNF cost per diem, and total ICF-type days furnished to all classes of patients multiplied by the appropriate ICF cost per diem, will be subtracted from inpatient general routine service costs. The cost per diem for inpatient general routine hospital care will be based on the remaining general routine service costs.

(v) Costs other than general inpatient routine service costs will be determined in the same manner as specified in the Departmental Method in paragraph (a)(1) of this section.

(3) *Cost per visit by type-of-service method—HHAs.* For cost reporting periods beginning on or after October 1, 1980, all HHAs must use the cost per visit by type-of-service method of apportioning costs between Medicare and non-Medicare beneficiaries. Under this method, the total allowable cost of all visits for each type of service is divided by the total number of visits for that type of service. Next, for each type of service, the number of Medicare covered visits is multiplied by the average cost per visit just computed. This represents the cost Medicare will recognize as the cost for that service, subject to cost limits published by HCFA (see § 413.30).

(b) *Definitions.* As used in this section—

"Ancillary services" means the services for which charges are customarily made in addition to routine services.

"Apportionment" means an allocation or distribution of allowable cost between the beneficiaries of the Medicare program and other patients.

"Average cost per diem for general routine services" means the following:

(1) For cost reporting periods beginning on or after October 1, 1982, subject to the provisions on swing-bed hospitals, the average cost of general routine services net of the private room cost differential. The average cost per diem is computed by the following methodology:

(i) Determine the total private room cost differential by multiplying the average per diem private room cost differential determined in paragraph (c) of this section by the total number of private room patient days.

(ii) Determine the total inpatient general routine service costs net of the total private room cost differential by subtracting the total private room cost differential from total inpatient general routine service costs.

(iii) Determine the average cost per diem by dividing the total inpatient general routine service cost net of private room cost differential by all inpatient general routine days, including total private room days.

(2) Fro swing-bed hospitals, the amount computed by—(i) Subtracting the costs attributable to SNF-type and ICF-type services from the total allowable inpatient cost for routine services (excluding the cost of services provided in intensive care units, coronary care units, and other intensive care type inpatient hospital units, and nursery costs); and (ii) dividing the remainder (excluding the total private room cost differential) by the total number of inpatient hospital days of care (excluding SNF-type and ICF-type days of care, days of care in intensive care units, coronary care units, and other intensive care type inpatient hospital units, and newborn days and including total private room days).

"Average cost per diem for hospital intensive care type units" means the amount computed by dividing the total allowable costs for routine services in each of these units by the total number of inpatient days of care furnished in each of these units.

"Average per diem private room cost differential" means the difference in the average per diem cost of furnishing routine services in a private room and in a semi-private room. (This differential is not applicable to hospital intensive care type units.) (The method for computing this differential is described in paragraph (c) of this section.)

"Charges" means the regular rates for various services that are charged to both beneficiaries and other paying patients who receive the services. Implicit in the use of charges as the basis for apportionment is the objective that charges for services be related to the cost of the services.

"ICF-type services" means routine services furnished by a swing-bed hospital that would constitute intermediate care facility (ICF) services, as defined in § 440.150 of this chapter, if furnished by an ICF. ICF-type services are not covered under the Medicare program.

"Intensive care type inpatient hospital unit" means a hospital unit that furnishes services to critically ill inpatients. Examples of intensive care type units include, but are not limited to, intensive care units, trauma units, coronary care units, pulmonary care units, and burn units. Excluded as intensive care type units are postoperative recovery rooms, postanesthesia recovery rooms, maternity labor rooms, and subintensive or intermediate care units. (The unit must also meet the criteria of paragraph (d) of this section.)

"SNF-type services" means routine services furnished by a swing-bed hospital that would constitute extended care services if furnished by an SNF. SNF-type services include routine services furnished in the distinct part SNF of a hospital complex that is combined with the hospital general routine service area cost center under § 413.24(d)(5).

"Ratio of beneficiary charges to total charges on a departmental basis" means the ratio of charges to beneficiaries of the Medicare program for services of a revenue-producing department or center to the charges to all patients for that center during an accounting period. After each revenue-producing center's ratio is determined, the cost of services furnished to beneficiaries of the Medicare program is computed by applying the individual ratio for the center to the cost of the related center for the period.

"Routine services" means the regular room, dietary, and nursing services, minor medical and surgical supplies, and the use of equipment and facilities for which a separate charge is not customarily made.

(c) *Method for computing the average per diem private room cost differential.* Compute the average per diem private room cost differential as follows:

(1) Determine the average per diem private room charge differential by subtracting the average pr diem charge for all semi-private room accommodations from the average per diem charge for all private room accommodations. The average per diem charge for private room accommodations is determined by dividing the total charges for private room accommodations by the total number of days of care furnished in private room accommodations. The average per diem charge for semi-private accommodations is determined by dividing the total charges for semi-private room accommodations by the total number of days of care furnished in semi-private accommodations.

(2) Determine the inpatient general routine cost to charge ratio by dividing total inpatient general routine service cost by the total inpatient general routine service charges.

(3) Determine the average per diem private room cost differential by multiplying the average per diem private room charge differential determined in paragraph (c)(1) of this section by the ratio determined in paragraph (c)(2) of this section.

(d) *Criteria for identifying intensive care type units.* For purposes of determining costs under this section, a unit will be identified as an intensive care type inpatient hospital unit only if the unit—

(1) Is in a hospital;

(2) Is physically and identifiably separate from general routine patient care areas, including subintensive or intermediate care units, and ancillary service areas. There cannot be a concurrent sharing of nursing staff between an intensive care type unit and units or areas furnishing different levels or types of care. However, two or more intensive care type units that concurrently share nursing staff can be reimbursed as one combined intensive care type unit if all other criteria are met. Float nurses (nurses who work in different units on an as-needed basis) can be utilized in the intensive care type unit. If a float nurse works in two different units during the same eight hour shift, then the costs must be allocated to the appropriate units depending upon the time spent in those untis. The hospital must maintain adequate records to support the allocation. If such records are not available, then the costs must be allocated to the general routine services cost areas;

(3) Has specific written policies that include criteria for admission to, and discharge from, the unit;

(4) Has registered nursing care available on a continuous 24-hour basis with at least one registered nurse present in the unit at all times;

(5) Maintains a minimum nurse-patient ratio of one nurse to two patients per patient day. Included in the calculation of this nurse-patient ratio are registered nurses, licensed vocational nurses, licensed practical nurses, and nursing assistants who provide patient care. Not included are general support personnel such as ward clerks, custodians, and housekeeping personnel; and

(6) Is equipped, or has available for immediate use, life-saving equipment necessary to treat the critically ill patients for which it is designed. This equipment may include, but is not limited to, respiratory and cardiac monitoring equipment, respirators, cardiac defibrillators, and wall or canister oxygen and compressed air.

(e) *Application*—(1) *Departmental method; Cost reporting periods beginning on or after October 1, 1982.*

(i) The following example illustrates how costs would be determined, using only inpatient data, for cost reporting

periods beginning on or after October 1, 1982, based on apportionment of—

(A) The average cost per diem for general routine services (subject to the private room differential provisions of paragraph (a)(1)(iii) of this section);

(B) The average cost per diem for each intensive care type unit;

(C) The ratio of beneficiary charges to total charges applied to cost by department.

HOSPITAL Y

Department	Charges to program beneficiaries	Total charges	Ratio of beneficiary charges to total charges	Total cost	Cost of beneficiary services
			Percent		
Operating rooms	$20,000	$70,000	28½	$77,000	$22,000
Delivery rooms	0	12,000	0	30,000	0
Pharmacy	20,000	60,000	33⅓	45,000	15,000
X-ray	24,000	100,000	24	75,000	18,000
Laboratory	40,000	140,000	28½	98,000	28,000
Others	6,000	30,000	20	25,000	5,000
Total	110,000	412,000		350,000	88,000

	Total inpatient days	Total cost	Average cost per diem	Program in patient days	Cost of beneficiary services
General routine	30,000	$630,000	$21	8,000	$168,000
Coronary care unit	500	20,000	40	200	8,000
Intensive care unit	3,000	108,000	36	1,000	36,000
	33,500	758,000		9,200	212,000
Total					300,000

(ii) The following illustrates how apportionment based on an average cost per diem for general routine services is determined.

HOSPITAL E

Facts	Private accommodations	Semi-private accommodations	Total
Total charges	$20,000	$175,000	$195,000
Total days	100	1,000	1,100
Programs days	70	400	470
Medically necessary for program beneficiaries	20		20
Total general routine service costs			165,000
Average private room per diem charge ($20,000 private room charges ÷ 100 days)			[1] $200
Average semi-private room per diem charge ($175,000 semi-private charge ÷ 1,000 days)			[1] $175

[1] Per diem.

Average per diem private room cost differential.

1. Averagae per diem private room charge differential ($200 private room per diem—$175, semi-private room per diem), $25.
2. Inpatient general routine cost/charge ratio ($165,000 total costs ÷ $195,000 total charges), 0.8461538.
3. Average per diem private room cost differential ($25 charge differential × .8461538 cost/charge ratio), $21.15.

Average cost per diem for inpatient general routine services.

4. Total private room cost differential ($21.15 average per diem cost differential × 100 private room days), $2,115.
5. Total inpatient general routine service costs net of private room cost differential ($165,000 total routine cost −$2,115 private room cost differential), $162,885.
6. Average cost per diem for inpatient general routine services ($162,885 routine cost net of private room cost differential ÷ 1,100 patient days), $148.08.

Medicare general routine service cost.

7. Total routine per diem cost applicable to Medicare ($148.08 average cost per diem × 470 Medicare private and semi-private patient days), $69,598.
8. Total private room cost differential applicable to Medicare (21.15 average per diem private room cost differential × 20 medically necessary private room days), $423.
9. Medicare inpatient general routine service cost ($423 Medicare private room cost differential + $69,598 Medicare cost of general routine inpatient services), $70,021.

(2) *Carve out method.* The following illustrates how apportionment is determined in a hospital reimbursed under the carve out method (subject to the private room differential provisions of paragraph (a)(1)(ii) of this section):

HOSPITAL K

[Determination of cost of routine SNF-type and ICF-type services and general routine hospital services[1]]

Facts	Days of care		
	General routine hospital	SNF-type	ICF-type
Total days of care	2,000	400	100
Medicare days of care	600	300	
Average medicaid rate	N/A	$35	$20

Total inpatient general routine service costs: $250,000

Calculation of cost of routine SNF-type services applicable to medicare:
$35 × 300 = $10,500

Calculation of cost of general routine hospital services:
Cost of SNF-type services: $35 × 400 ..... $14,000
Cost ICF-type services: $20 × 100 2,000
Total $16,000

Average cost per diem of general routine hospital services:
$250,000 — $16,000 ÷ 2,000 days = $117

Medicare general routine hospital cost:
$117 × 600 = $70,200

Total medicare reasonable cost for general routine inpatient days:
$10,500 + $70,200 = $80,700

§ 413.56 Malpractice insurance costs.

(a) *Apportionment of malpractice insurance premiums and self-insurance fund contributions.* For cost reporting periods beginning on or after July 1, 1979, malpractice insurance costs must be apportioned as set forth in this section. Subject to the rules of administrative finality and reopening as set forth in Subpart R of this part, hospital malpractice insurance premiums and self-insurance fund contributions must be separately accumulated and directly apportioned to Medicare based on the methodology described in paragraph (b) of this section. Allowable malpractice insurance costs of SNFs must be apportioned to Medicare based on the methodology described in paragraph (c) of this section. For purposes of this section, "premium" includes contributions to malpractice self insurance funds.

(b) *Hospital malpractice insurance cost methodology.* (1) *Components of the premium.* The premium is divided into

an administrative component and a risk component as follows:

(i) The administrative component consists of 8.5 percent of the total premium amount, and accounts for an insurer's fixed overhead expenses and a proportionate share of premium and payroll taxes and commissions paid to insurance agents.

(ii) The risk component consists of 91.5 percent of the total premium amount, and accounts for an insurer's anticipated loss experience, expenses associated with losses (including defense costs and claims department overhead costs), and the remaining share of taxes and commissions paid to insurance agents that are not included in the administrative component.

(2) *Apportionment of administrative component.* The administrative component of the premium is reported as an administrative and general cost and apportioned in accordance with § 413.53(a)(1).

(3) *Apportionment of risk component.* (i) The risk component of the premium is apportioned based on a scaling factor, derived from the scaling factor formula described in paragraph (b)(3)(ii) of this section, which accounts for the hospital's Medicare utilization rate and the disproportionately low national ratio of hospital malpractice losses paid to Medicare beneficiaries, as compared to losses paid to all patients. The scaling factor is multiplied by 91.5 percent of the hospital's malpractice insurance premium to determine Medicare's share of the risk component of the premium.

(ii) The scaling factor is derived from the following formula:

$$\frac{u \times (R/U_1)}{[u \times (R/U_1)] + [(1-u) \times (1-R)/(1-U_2)]}$$

U_1 = The national Medicare hospital patient utilization rate, as adjusted for the time lag between incident and claim closure for Medicare patients.

U_2 = The national Medicare hospital patient utilization rate, as adjusted for the time lag between incident and claim closure for non-Medicare patients.

R = The national Medicare malpractice loss ratio, as adjusted for associated claims handling expense.

u = The hospital's own Medicare utilization rate for the cost reporting period based on a ratio of the hospital's total Medicare-covered inpatient days of care to its total inpatient days of care.

R/U_1 = The national Medicare malpractice loss ratio compared to the national Medicare utilization rate.

$(1-R)/(1-U_2)$ = The national non-Medicare malpractice loss ratio compared to the national non-Medicare utilization rate.

(4) *Example:* Apportionment of Medicare's share of the malpractice insurance costs of a hospital that averages 75 percent Medicare utilization during the applicable cost reporting period is calculated as follows:

Step one—The administrative component of the premium (8.5 percent) is included in the administrative and general cost center of the hospital and is apportioned on a utilization basis. This, the hospital would be reimbursed approximately .085 times .75, or 6.38 percent of the administrative component of its premium. (This figure would vary slightly depending upon the hospital's specific Medicare utilization of its patient care departments.)

Step two—The risk component of the premium (91.5 percent) is apportioned on a basis which accounts for the hospital's own Medicare patient utilization rate and the adjusted national Medicare malpractice loss ratio by multiplying 91.5 percent by the .421 scaling factor derived from the scaling factor formula, as follows:

u = 75.0 percent
R = 13.2 percent
U_1 = 38.8 percent
U_2 = 38.1 percent

$$\frac{.75 \times (.132/.388)}{[.75 \times (.132/.388)] + [(1-.75) \times (1-.132)/(1-.381)]} = .421$$

Thus, the hospital would be reimbursed .915 times .421, or 38.54 percent of the risk component of its premium. This means that Medicare reimbursement would account for 6.38 percent plus 38.54 percent, or 44.92 percent of this hospital's total malpractice insurance premium.

(5) *Updating of factors used in determining apportionment.* Based on actual cost reports data, HCFA will periodically calculate the national average of Medicare utilization and the national ratio of hospital malpractice losses paid to Medicare beneficiaries to malpractice losses paid to all hospital patients. Periodically, as warranted by changes in these factors, HCFA will—

(i) Publish a notice in the **Federal Register** describing the proposed changes for public comment; and

(ii) In a subsequent **Federal Register** notice, update the relevant factors and respond to comments.

(6) *Allowable uninsured malpractice losses and related direct costs incurred by a hospital.* If a hospital pays an allowable uninsured malpractice loss to or on behalf of a Medicare beneficiary in order to comply with a deductible or coinsurance policy, or as a result of an award in excess of a reasonable coverage limit, or as a governmental provider, that loss and related direct costs must be directly assigned to Medicare for reimbursement. An uninsured malpractice loss paid to or on behalf of a non-Medicare patient is not an allowable cost.

(c) *SNF malpractice insurance cost methodology.* Costs of malpractice insurance premiums and self-insurance fund contributions, in addition to other allowable malpractice insurance costs of an SNF, are reported as an administrative and general cost and apportioned in accordance with § 413.53(a)(1).

Subpart E—Payments to Providers

§ 413.60 Payments to providers: General.

(a) The fiscal intermediaries will establish a basis for interim payments to each provider. This may be done by one of several methods. If an intermediary is already paying the provider on a cost basis, the intermediary may adjust its rate of payment to an estimate of the result under the Medicare principles of reimbursement. If no organization is paying the provider on a cost basis, the intermediary may obtain the previous year's financial statement from the provider and, by applying the principles of reimbursement, compute or approximate an appropriate rate of payment. The interim payment may be related to the last year's average per diem, or to charges, or to any other ready basis of approximating costs.

(b) At the end of the period, the actual apportionment, based on the cost finding and apportionment methods selected by the provider, determines the Medicare reimbursement for the actual services provided to beneficiaries during the period.

(c) Basically, therefore, interim payments to providers will be made for services throughout the year, with final settlement on a retroactive basis at the end of the accounting period. Interim

payments will be made as often as possible and in no event less frequently than once a month. The retroactive payments will take fully into account the costs that were actually incurred and settle on an actual, rather than on an estimated basis.

§ 413.64 Payments to providers: Specific rules.

(a) *Principle*—(1) *Reimbursement on a reasonable cost basis.* Providers of services paid on the basis of the reasonable cost of services furnished to beneficiaries will receive interim payments approximating the actual costs of the provider. These payments will be made on the most expeditious schedule administratively feasible but not less often than monthly. A retroactive adjustment based on actual costs will be made at the end of reporting period.

(2) *Payments under the prospective payment system.* For cost reporting periods beginning on or after October 1, 1983, hospitals and hospital units (see § 413.1(d)) are paid a prospectively determined rate under Part 412 of this chapter for Medicare Part A inpatient operating costs on a per discharge basis. Part A inpatient hospital operating costs include those costs (including malpractice costs) for general routine services, ancillary services, and intensive care-type unit services with respect to inpatient hospital services but exclude capital-related and direct medical education costs. Payments for capital-related and direct medical education applicable to inpatient costs that are payable under Part A, for certain kidney acquisition costs of renal transplantation centers (see § 405.2102(e)(1) of this chapter), and for medical and other health services furnished to inpatients under Part B and outpatient services with respect to such hospitals and hospital units continue on a reasonable cost basis. The method of payment for hospitals under the prospective payment system is described in paragraph (k) of this section.

(b) *Amount and frequency of payment.* Medicare states that providers of services will be paid the reasonable cost of services furnished to beneficiaries. Since actual costs of services cannot be determined until the end of the accounting period, the providers must be paid on an estimated cost basis during the year. While Medicare provides that interim payments will be made no less often than monthly, intermediaries are expected to make payments on the most expeditious basis administratively feasible. Whatever estimated cost basis is used for determining interim payments during the year, the intent is that the interim payments shall approximate actual costs as nearly as is practicable so that the retroactive adjustment based on actual costs will be as small as possible.

(c) *Interim payments during initial reporting period.* At the beginning of the program or when a provider first participates in the program, it will be necessary to establish interim rates of payment to providers of services. Once a provider has filed a cost report under the Medicare program, the cost report may be used as a basis for determining the interim rate of reimbursement for the following period. However, since initially there is no previous history of cost under the program, the interim rate of payment must be determined by other methods, including the following:

(1) If the intermediary is already paying the provider on a cost or cost-related basis, the intermediary will adjust its rate of payment to the program's principles of reimbursement. This rate may be either an amount per inpatient day, or a percent of the provider's charges for services furnished to the program's beneficiaries.

(2) If an organization other than the intermediary is paying the provider for services on a cost or cost-related basis, the intermediary may obtain from that organization or from the provider itself the rate of payment being used and other cost information as may be needed to adjust that rate of payment to give recognition to the program's principles of reimbursement.

(3) It no organization is paying the provider on a cost or cost-related basis, the intermediary will obtain the previous year's financial statement from the provider. By analysis of such statement in the light of the principles of reimbursement, the intermediary will compute an appropriate rate of payment.

(4) After the initial interim rate has been set, the provider may at any time request, and be allowed, an appropriate increase in the computed rate, upon presentation of satisfactory evidence to the intermediary that costs have increased. Likewise, the intermediary may adjust the interim rate of payment if it has evidence that actual costs may fall significantly below the computed rate.

(d) *Interim payments for new providers.* (1) Newly-established providers will not have cost experience on which to base a determination of an interim rate of payment. In such cases, the intermediary will use the following methods to determine an appropriate rate:

(i) If there is a provider or providers comparable in substantially all relevant factors to the provider for which the rate is needed, the intermediary will base an interim rate of payment on the costs of the comparable provider.

(ii) If there are no substantially comparable providers from whom data are available, the intermediary will determine an interim rate of payment based on the budgeted or projected costs of the provider.

(2) Under either method, the intermediary will review the provider's cost experience after a period of three months. If need for an adjustment is indicated, the interim rate of payment will be adjusted in line with the provider's cost experience.

(e) *Interim payments after initial reporting period.* Interim rates of payment for services provided after the initial reporting period will be established on the basis of the cost report filed for the previous year covering Medicare services. The current rate will be determined—whether on a per diem or percentage of charges basis—using the previous year's costs of covered services and making any appropriate adjustments required to bring, as closely as possible, the current year's rate of interim payment into agreement with current year's costs. This interim rate of payment may be adjusted by the intermediary during an accounting period if the provider submits appropriate evidence that its actual costs are or will be significantly higher than the computed rate. Likewise, the intermediary may adjust the interim rate of payment if it has evidence that actual costs may fall significantly below the computed rate.

(f) *Retroactive adjustment.* (1) Medicare provides that providers of services will be paid amounts determined to be due, but not less often than monthly, with necessary adjustments due to previously made overpayments or underpayments. Interim payments are made on the basis of estimated costs. Actual costs reimbursable to a provider cannot be determined until the cost reports are filed and costs are verified. Therefore, a retroactive adjustment will be made at the end of the reporting period to bring the interim payments made to the provider during the period into agreement with the reimbursable amount payable to the provider for the services furnished to program beneficiaries during that period.

(2) In order to reimburse the provider as quickly as possible, an initial retroactive adjustment will be made as soon as the cost report is received. For

this purpose, the costs will be accepted as reported, unless there are obvious errors or inconsistencies, subject to later audit. When an audit is made and the final liability of the program is determined, a final adjustment will be made.

(3) To determine the retroactive adjustment, the amount of the provider's total allowable cost apportioned to the program for the reporting year is computed. This is the total amount of reimbursement the provider is due to receive from the program and the beneficiaries for covered services furnished during the reporting period. The total of the interim payments made by the program in the reporting year and the deductibles and coinsurance amounts receivable from beneficiaries is computed. The difference between the reimbursement due and the payments made in the amount of the retroactive adjustment.

(g) *Accelerated payments to providers.* Upon request, an accelerated payment may be made to a provider of services if the provider has experienced financial difficulties due to a delay by the intermediary in making payments or in exceptional situations, in which the provider has experienced a temporary delay in preparing and submitting bills to the intermediary beyond its normal billing cycle. Any such payment must be approved first by the intermediary and then by HCFA. The amount of the payment is computed as a percentage of the net reimbursement for unbilled or unpaid covered services. Recovery of the accelerated payment may be made by recoupment as provider bills are processed or by direct payment.

(h) *Periodic interim payment method of reimbursement.*—(1)(i) *Covered services furnished before July 1, 1987.* In addition to the regular methods of interim payment on individual provider billings for covered services, the periodic interim payment (PIP) method is available for Part A hospital and SNF inpatient services and for both Part A and Part B HHA services.

(ii) *Covered services furnished on or after July 1, 1987.* Effective with covered services furnished to beneficiaries on or after July 1, 1987, the PIP method, in addition to the other methods of interim payment on individual provider billings for covered services, is available only for the following:

(A) Part A SNF services.

(B) Part A and Part B HHA services.

(C) Part A services furnished in hospitals receiving payment in accordance with a demonstration project authorized under section 402(a) of Pub. L. 90–248 (42 U.S.C. 1395b–1) or section 222(a) of Pub. L. 92–603 (42 U.S.C. 1395b–1 (note)), or a State reimbursement control system approved under section 1886(c) of the Act and Subpart C of Part 403 of this chapter, if that type of payment is specifically approved by HCFA as a part of the demonstration on control system.

(D) Part A services furnished in hospitals located in a rural area as defined in § 412.62(f) of this chapter that have fewer than 100 beds available for use excluding beds assigned to newborns.

(2) Any participating provider furnishing the services described in paragraph (h)(1) of this section that establishes to the satisfaction of the intermediary that it meets the following requirements may elect to be reimbursed under the PIP method, beginning with the first month after its request that the intermediary finds administratively feasible:

(i) The provider's estimated total Medicare reimbursement for inpatient services is at least $25,000 a year computed under the PIP formula or, in the case of an HHA, either its estimated—

(A) Total Medicare reimbursement for Part A and Part B services is a least $25,000 a year computed under the PIP formula; or

(B) Medicare reimbursement computed under the PIP formula is at least 50 percent of estimated total allowable cost.

(ii) The provider has filed at least one completed Medicare cost report accepted by the intermediary as providing an accurate basis for computation of program payment (except in the case of a provider requesting reimbursement under the PIP method upon first entering the Medicare program).

(iii) The provider has the continuing capability of maintaining in its records the cost, charge, and statistical data needed to accurately complete a Medicare cost report on a timely basis.

(iv) The provider has repaid or agrees to repay any outstanding current financing payment in full, such payment to be made before the effective date of its requested conversion from a regular interim payment method to the PIP method.

(3) No conversion to the PIP method may be made with respect to any provider until after that provider has repaid in full its outstanding current financing payment.

(4) The intermediary's approval of a provider's request for reimbursement under the PIP method will be conditioned upon the intermediary's best judgment as to whether payment can be made to the provider under the PIP method without undue risk of its resulting in an overpayment because of greatly varying or substantially declining Medicare utilization, inadequate billing practices, or other circumstances. The intermediary may terminate PIP reimbursement to a provider at any time it determines that the provider no longer meets the qualifying requirements or that the provider's experience under the PIP method shows that proper payment cannot be made under this method.

(5) Payment will be made biweekly under the PIP method unless the provider requests a longer fixed interval (not to exceed one month) between payments. The payment amount will be computed by the intermediary to approximate, on the average, the cost of covered inpatient or home health services furnished by the provider during the period for which the payment is to be made, and each payment will be made two weeks after the end of such period of services. Upon request, the intermediary will, if feasible, compute the provider's payments to recognize significant seasonal variation in Medicare utilization of services on a quarterly basis starting with the beginning of the provider's reporting year.

(6) A provider's PIP amount may be appropriately adjusted at any time if the provider presents or the intermediary otherwise obtains evidence relating to the provider's costs or Medicare utilization that warrants such adjustment. In addition, the intermediary will recompute the payment immediately upon completion of the desk review of a provider's cost report and also at regular intervals not less often than quarterly. The intermediary may make a retroactive lump sum interim payment to a provider, based upon an increase in its PIP amount, in order to bring past interim payments for the provider's current cost reporting period into line with the adjusted payment amount. The objective of intermediary monitoring of provider costs and utilization is to assure payments approximating, as closely as possible, the reimbursement to be determined at settlement for the cost reporting period. A significant factor in evaluating the amount of the payment in terms of the realization of the projected Medicare utilization of services is the timely submittal to the intermediary of completed admission and billing forms. All providers must complete billings in detail under this method as under regular interim payment procedures.

(i) *Bankruptcy or insolvency of provider.* If on the basis of reliable

evidence, the intermediary has a valid basis for believing that, with respect to a provider, proceedings have been or will shortly be instituted in a State or Federal court for purposes of determining whether such provider is insolvent or bankrupt under an appropriate State or Federal law, any payments to the provider will be adjusted by the intermediary, notwithstanding any other regulation or program instruction regarding the timing or manner of such adjustments, to a level necessary to insure that no overpayment to the provider is made.

(j) *Interest payments resulting from judicial review*—(1) *Application.* If a provider of services seeks judicial review by a Federal court (see § 405.1877 of this chapter) of a decision furnished by the Provider Reimbursement Review Board or subsequent reversal, affirmation, or modification by the Secretary, the amount of any award of such Federal court will be increased by interest payable by the party against whom the judgment is made (see § 413.153 for treatment of interest). The interest is payable for the period beginning on the first day of the first month following the 180-day period which began on either the date the intermediary made a final determination or the date the intermediary would have made a final determination had it been done on a timely basis (see §§ 405.1835(b) and 405.1841(a) of this chapter).

(2) *Amount due.* Section 1878(f) of the Act, 42 U.S.C. 1395oo(f), authorizes a court to award interest in favor of the prevailing party on any amount due as a result of the court's decision. If the intermediary withheld any portion of the amount in controversy prior to the date the provider seeks judicial review by a Federal court, and the Medicare program is the prevailing party, interest is payable by the provider only on the amount not withheld. Similarly, if the Medicare program seeks to recover amounts previously paid to a provider, and the provider is the prevailing party, interest on the amounts previously paid to a provider is not payable by the Medicare program since that amount had been paid and is not due the provider.

(3) *Rate.* The amount of interest to be paid is equal to the rate of return on equity capital (see § 413.157) in effect for the month in which the civil action is commenced.

Example: An intermediary made a final determinaton on the amount of Medicare program reimbursement on June 15, 1974, and the provider appealed that determination to the Provider Reimbursement Review Board. The Board heard the appeal and rendered a decision adverse to the provider. On October 28, 1974, the provider commenced civil action to have such decision reviewed. The rate of return on equity capital for the month of October 1974 was 11.625 percent. The period for which interest is computed begins on January 1, 1975, and the interest beginning January 1, 1975, would be at the rate of 11.625 percent per annum.

(k) *Prospective payments.*—(1) *General rule.*—(i) *Final payment.* For cost reporting periods beginning on or after October 1, 1983, hospitals subject to the prospective payment system are paid for Part A inpatient operating costs on a per discharge basis using prospectively determined rates. The amounts represent final payment based on the submission of a discharge bill. Unless the provisions of paragraphs (k)(2) through (k)(5) of this section apply, year-end retroactive adjustments are not made for prospective payment hospitals.

(ii) *Outlier payments.* Payments for outlier cases (described in Subpart F of Part 412 of this chapter) are not made on an interim basis. The outlier payments are made based on submitted bills and represent final payment.

(iii) *Other payments.* Medical education costs are reimbursed as described in § 413.85, and capital-related costs are reimbursed as described in § 413.130.

(2) *Interim prospective payments per discharge.* (i) Except as provided in paragraph (k)(2)(ii) of this section, prospective payment hospitals meeting the criteria in paragraph (h) of this section may elect to receive periodic interim payments for discharges occurring before July 1, 1987. Therefore, at the discretion of the intermediary, the hospital's prospective payments are estimated and made on a periodic interim basis (26 biweekly payments). These payments are subject to final settlement. Each payment is made two weeks after the end of a biweekly period of services, as described in paragraph (h)(5) of this section. Hospitals electing periodic interim payments may convert to payments on a per discharge basis at any time.

(ii) Prospective payment hospitals located in a rural area as defined in § 412.62(f) of this chapter that have fewer than 100 beds available for use excluding beds assigned to newborns and meet the criteria in paragraph (h) of this section may elect to receive periodic interim payments for discharges occurring on or after July 1, 1987.

(iii) For the hospitals receiving periodic interim payments for inpatient operating costs, the biweekly interim payment amount is based on the total estimated Medicare discharges for the reporting period multiplied by the hospital's estimated average prospective payment amount. These interim payments are reviewed at least twice during the reporting period and adjusted if necessary.

(iv) For purposes of determining periodic interim payments under this paragraph, the intermediary computes a hospital's estimated average prospective payment amount by multiplying its transition payment rates as determined under § 412.70(c) of this chapter, but without adjustment by a DRG weighting factor, by the hospital's case-mix index, and subtracting from this amount estimated deductibles and coinsurance.

(3) *Special interim payments for certain costs.* For capital-related costs and the direct costs of medical education, which are not included in prospective payments but are reimbursed as specified in §§ 413.130 and 413.85, respectively, interim payments are made subject to final cost settlement. Interim payments for capital-related items and the estimated cost of approved medical education programs (applicable to inpatient costs payable under Part A and for kidney acquisition costs in hospitals approved as renal transplantation centers) are determined by estimating the reimbursable amount for the year based on the previous year's experience and on substantiated information for the current year and divided into 26 equal biweekly payments. Each payment is made two weeks after the end of a biweekly period of services, as described in paragraph (h)(5) of this section. The interim payments are reviewed by the intermediary at least twice during the reporting period and adjusted if necessary.

(4) *Special interim payments for the indirect costs of medical education.* Payments for the indirect costs of medical education (described in § 412.118 of this chapter) are paid based on an estimate of the total for the Federal portion of the diagnosis-related group revenue to be received in the current period. The total estimated annual amount of the adjustment is divided into 26 equal biweekly payments and included with other inpatient costs reimbursed on a reasonable cost basis. This estimate is subject to year-end adjustment. Each payment is made two weeks after the end of a biweekly period of services. The interim payments are reviewed by the intermediary at least twice during their reporting period and adiusted if necessary.

(5) *Special interim payments for unusually long lengths of stay.* For

discharges occurring on or after July 1, 1987, a hospital may request an interim payment if a Medicare beneficiary's length of stay exceeds 30 days. The amount of the interim payment is equal to the hospital's Federal rate multiplied by the appropriate diagnosis-related group weighting factor. Only one interim payment per discharge is permitted.

§ 413.74 Payment to a foreign hospital.

(a) *Principle.* Section 1814(f) of the Act provides for the payment of emergency and nonemergency inpatient hospital services furnished by foreign hospitals to Medicare beneficiaries. Section 405.153 of this chapter, together with this section, specify the conditions for payment. These conditions may result in payments only to Canadian and Mexican hospitals.

(b) *Amount of payment.* Effective with admissions on or after January 1, 1980, the reasonable cost for services covered under the Medicare program furnished to beneficiaries by a foreign hospital will be equal to 100 percent of the hospital's customary charges (as defined in § 413.13(b)) for the services.

(c) *Submittal of claims.* The hospital must establish its customary charges for the services by submitting an itemized bill with each claim it files in accordance with its election under § 405.658 of this chapter.

(d) *Exchange rate.* Payment to the hospital will be subject to the official exchange rate on the date the patient is discharged and to the applicable deductible and coinsurance amounts described in §§ 409.80 through 409.83.

Subpart F—Specific Categories of Costs

§ 413.80 Bad debts, charity, and courtesy allowances.

(a) *Principle.* Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost; however, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the program.

(b) *Definitions—(1) Bad debts.* Bad debts are amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the furnishing of services, and are collectible in money in the relatively near future.

(2) *Charity allowances.* Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient. Cost of free care (uncompensated services) furnished under a Hill-Burton obligation are considered as charity allowances.

(3) *Courtesy allowances.* Courtesy allowances indicate a reduction in charges in the form of an allowance to physicians, clergy, members of religious orders, and otheres as approved by the governing body of the provider, for services received from the provider. Employee fringe benefits, such as hospitaliation and personnel health programs, are not considered to be courtesy allowances.

(c) *Normal accounting treatment: Reduction in revenue.* Bad debts, charity, and courtesy allowances represent reductions in revenue. The failure to collect charges for services furnished does not add to the cost of providing the services. Such costs have already been incurred in the production of the services.

(d) *Requirements for Medicare.* Under Medicare, costs of covered services furnished beneficiaries are not to be borne by individuals not covered by the Medicare program, and conversely, costs of services provided for other than beneficiaries are not to be borne by the Medicare program. Uncollected revenue related to services furnished to beneficiaries of the program generally means the provider has not recovered the cost of services covered by that revenue. The failure of beneficiaries to pay the deductible and coinsurance amounts could result in the related costs of covered services being borne by other than Medicare beneficiaries. To assure that such covered service costs are not borne by others, the costs attributable to the deductible and coinsurance amounts that remain unpaid are added to the Medicare share of allowable costs. Bad debts arising from other sources are not allowable costs.

(e) *Criteria for allowable bad debt.* A bad debt must meet the following criteria to be allowable:

(1) The debt must be related to covered services and derived from deductible and coinsurance amounts.

(2) The provider must be able to establish that reasonable collection efforts were made.

(3) The debt was actually uncollectible when claimed as worthless.

(4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

(f) *Charging of bad debts and bad debt recoveries.* The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period; in such cases the income therefrom must be used to reduce the cost of beneficiary services for the period in which the collection is made.

(g) *Charity allowances.* Charity allowances have no relationship to beneficiaries of the Medicare program and are not allowable costs. These charity allowances include the costs of uncompensated services furnished under a Hill-Burton obligation. (Note: In accordance with Sec. 106(b) of Pub. L. 97–248 (enacted September 3, 1982), this sentence is effective with respect to any costs incurred under Medicare except that it does not apply to costs which have been allowed prior to September 3, 1982, pursuant to a final court order affirmed by a United States Court of Appeals.) The cost to the provider of employee fringe-benefit programs is an allowable element of reimbursement.

§ 413.85 Cost of educational activities.

(a) *Reimbursement*—(1) *General rule.* Except as provided in paragraph (a)(2) of this section, a provider's allowable cost may include its net cost of approved educational activities, as calculated under paragraph (g) of this section.

(2) *Limit applicable to cost reporting periods beginning on or after July 1, 1985 but before July 1, 1986.* (i) For cost reporting periods beginning on or after July 1, 1985 but before July 1, 1986, a provider's net cost of approved educational activities, as calculated under paragraph (g) of this section, incurred during a cost reporting period is limited, under the authority of section 1861(v)(1)(A) of the Act, to the lesser of the provider's net cost of its program—

(A) For that cost reporting period; or

(B) For a base year that consists of the provider's cost reporting period that began on or after October 1, 1983 but before October 1, 1984. For providers whose cost reporting periods began during the months of October 1983 through June 1984, the provider's net cost of its program is adjusted by an updating factor. The factor is based on the increase in the overall rate of inflation, according to the Consumer Price Index for All Urban Consumers, that occurred during the provider's base year.

(ii) For providers that did not have approved educational activities as of the first day of the cost reporting period that would otherwise be its base year defined in paragraph (a)(2)(i)(B) of this section, and that initiated such activities after the first month of that cost

reporting period, but prior to July 1, 1985, we will establish a base period for applying the limit described in this section. The base period will include allowable costs the provider incurred for approved educational activities prior to July 1, 1985, adjusted in order to be reasonably comparable to the base years of other providers.

(3) *Apportionment.* Once the net cost is determined under this section, it is subject to apportionment for Medicare utilization as described in § 405.403.

(b) *Definition—Approved educational activities.* Approved educational activities means formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities must be licensed if required by State law. If licensing is not required, the institution must receive approval from the recognized national professional organization for the particular activity.

(c) *Educational activities.* Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

(d) *Activities not within the scope of this principle.* The costs of the following activities are not within the scope of this principle but are recognized as normal operating costs and are reimbursed in accordance with applicable principles—

(1) Orientation and on-the-job training;

(2) Part-time education for bona fide employees at properly accredited academic or technical institutions (including other providers) devoted to undergraduate or graduate work;

(3) Costs, including associated travel expense, or sending employees to educational seminars and workshops that increase the quality of medical care or operating efficiency of the provider;

(4) Maintenance of a medical library;

(5) Training of a patient or patient's family in the use of medical appliances;

(6) Clinical training of students not enrolled in an approved enducation program operated by the provider; and

(7) Other activities that do not involve the actual operation of an approved education program including the costs of interns and residents in anesthesiology who are are employed to replace anesthetists.

(e) *Approved programs.* In addition to approved medical, osteopathic, dental, and podiatry internships and residency programs[1] recognized professional and paramedical educational and training programs now being conducted by provider institutions, and their approving bodies, and include the following:

Program	Approving bodies
(1) Cytotechnology	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
(2) Dietetic internships	The American Dietetic Association.
(3) Hospital administration residencies	Members of the Association of University Programs in Hospital Administration.
(4) Inhalation therapy	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Inhalation Therapy.
(5) Medical records	Council on Medical Education of the American Medical Association in collaboration with the Committee on Education and Registration of the American Association of Medical Record Librarians.
(6) Medical technology	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
(7) Nurse anesthetists	The American Association of Nurse Anesthetists.
(8) Professional nursing	Approved by the respective State approving authorities. Reported for the United States by the National League for Nursing.
(9) Practical nursing	Approved by the respective State approving authorities. Reported for the United States by the National League for Nursing.
(10) Occupational therapy	Council on Medical Education of the American Medical Association in collaboration with the Council on Education of the American Occupational Therapy Association.
(11) Pharmacy residencies	American Society of Hospital Pharmacists.
(12) Physical therapy	Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association.
(13) X-ray technology	Council on Medical Education of the American Medical Association in collaboration with the American College of Radiology.

(f) *Other educational programs.* There may also be other educational programs not included in the foregoing in which a provider institution is engaged. Appropriate consideration will be given by the intermediary and HCFA to the costs incurred for those activities that come within the purview of the principle when determining the allowable costs for apportionment under the Medicare program.

(g) *Calculating net cost.* Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 413.24.

§ 413.90 Research costs.

(a) *Principle.* Costs incurred for research purposes, over and above usual patient care, are not includable as allowable costs.

(b) *Application.* (1) There are numerous sources of financing for health-related research activities. Funds for this purpose are provided under many Federal programs and by other tax-supported agencies. Also, many foundations, voluntary health agencies, and other private organizations, as well as individuals, sponsor or contribute to the support of medical and related research. Funds available from such sources are generally ample to meet basic medical and hospital research needs. A further consideration is that quality review should be assured as a condition of governmental support for research. Provisions for such review would introduce special difficulties in the Medicare programs.

(2) If research is conducted in conjunction with, and as a part of, the care of patients, the costs of usual patient care are allowable to the extent that such costs are not met by funds

[1] See § 409.15 of this chapter for a listing of such approved programs. For purposes of determination of educational costs in cost reporting periods beginning prior to January 1973, podiatry internships and residency programs approved by the Council on Podiatry Education of the American Podiatry Association were eligible for approval under paragraph (f) of this section.

provided for the research. Under this principle, however, studies, analyses, surveys, and related activities to serve the provider's administrative and program needs, are not excluded as allowable costs in the determination of reimbursement under Medicare.

§ 413.94 Value of services of nonpaid workers.

(a) *Principle.* The value of services in positions customarily held by full-time employees performed on a regular, scheduled basis by individuals as nonpaid members of organizations under arrangements between such organizations and a provider for the performance of such services without direct remuneration from the provider to such individuals is allowable as an operating expense for the determination of allowable cost subject to the limitation contained in paragraph (b) of this section. The amounts allowed are not to exceed those paid others for similar work. Such amounts must be identifiable in the records of the institutions as a legal obligation for operating expenses.

(b) *Limitations: Services of nonpaid workers.* The services must be performed on a regular, scheduled basis in positions customarily held by full-time employees and necessary to enable the provider to carry out the functions of normal patient care and operation of the institution. The value of services of a type for which providers generally do not remunerate individuals performing such services is not allowable as a reimbursable cost under the Medicare program. For example, donated services of individuals in distributing books and magazines to patients, or in serving in a provider canteen or cafeteria or in a provider gift shop, would not be reimbursable.

(c) *Application.* The following illustrates how a provider would determine an amount to be allowed under this principle: The prevailing salary for a lay nurse working in Hospital A is $5,000 for the year. The lay nurse receives no maintenance or special perquisites. A sister working as a nurse engaged in the same activities in the same hospital receives maintenance and special perquisites which cost the hospital $2,000 and are included in the hospital's allowable operating costs. The hospital would then include in its records an additional $3,000 to bring the value of the services rendered to $5,000. The amount of $3,000 would be allowable if the provider assumes obligation for the expense under a written agreement with the sisterhood or other religious order covering payment by the provider for the services.

§ 413.98 Purchase discounts and allowances, and refunds of expenses.

(a) *Principle.* Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense.

(b) *Definitions*—(1) *Discounts.* Discounts, in general, are reductions granted for the settlement of debts.

(2) *Allowances.* Allowances are deductions granted for damage, delay, shortage, imperfection, or other causes, excluding discounts and returns.

(3) *Refunds.* Refunds are amounts paid back or a credit allowed on account of an overcollection.

(c) *Normal accounting treatment—Reduction of costs.* All discounts, allowances, and refunds of expenses are reductions in the cost of goods or services purchased and are not income. If they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, if they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they are received.

(d) *Application.* (1) Purchase discounts have been classified as cash, trade, or quantity discounts. Cash discounts are reductions granted for the settlement of debts before they are due. Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms. Quantity discounts are reductions from list prices granted because of the size of individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing allowable costs is required. In the past, purchase discounts were considered as financial management income. However, modern accounting theory holds that income is not derived from a purchase but rather from a sale or an exchange and that purchase discounts are reductions in the cost of whatever was purchased. The true cost of the goods or services is the net amount actually paid for them. Treating purchase discounts as income would result in an overstatement of costs to the extent of the discount.

(2) As with discounts, allowances, and rebates received from purchases of goods or services, refunds of previous expense payments are clearly reductions in costs and must be reflected in the determination of allowable costs. This treatment is equitable and is in accord with that generally followed by other governmental programs and third-party payment organizations paying on the basis of cost.

§ 413.102 Compensation of owners.

(a) *Principle.* A reasonable allowance of compensation for services of owners is an allowable cost provided that the services are actually performed in a necessary function.

(b) *Definitions*—(1) *Compensation.* Compensation means the total benefit received by the owner for the services he furnishes to the institution. It includes the following items:

(i) Salary amounts paid for managerial, administrative, professional, and other services.

(ii) Amounts paid by the institution for the personal benefit of the proprietor.

(iii) The cost of assets and services that the proprietor receives from the institution.

(iv) Deferred compensation.

(2) *Reasonableness.* Reasonableness requires that the compensation allowance—

(i) Be such an amount as would ordinarily be paid for comparable services by comparable institutions; and

(ii) Depend upon the facts and circumstances of each case.

(3) *Necessary.* Necessary requires that the function be—

(i) Such that had the owner not furnished the services, the institution would have had to employ another person to perform the services; and

(ii) Pertinent to the operation and sound conduct of the institution.

(c) *Application.* (1) Owners of provider organizations often furnish services as managers, administrators, or in other capacities. In such cases, it is equitable that reasonable compensation for the services furnished to be an allowable cost. To do otherwise would disadvantage such owners in comparison with corporate providers or providers employing persons to perform similar services.

(2) Ordinarily, compensation paid to proprietors is a distribution of profits. However, if a proprietor furnishes necessary services for the institution, the institution is in effect employing his services, and a reasonable compensation for these services is an allowable cost. In corporate providers, the salaries of owners who are also employees are subject to the same requirements of reasonableness. If the services are furnished on less than a full-time basis, the allowable compensation should reflect an amount proportionate to a full-time basis. Reasonableness of compensation may be determined by reference to, or in

comparison with, compensation paid for comparable services and responsibilities in comparable institutions; or it may be determined by other appropriate means.

§ 413.106 Reasonable cost of physical and other therapy services furnished under arrangements.

(a) *Principle.* The reasonable cost of the services of physical, occupational, speech, and other therapists, and services of other health specialists (other than physicians), furnished under arrangements (as defined in section 1861(w) of the Act) with a provider of services, a clinic, a rehabilitation agency or a public health agency, may not exceed an amount equivalent to the prevailing salary and additional costs that would reasonably have been incurred by the provider or other organization had such services been performed by such person in an employment relationship, plus the cost of other reasonable expenses incurred by such person in furnishing services under such an arrangement. However, if the services of a therapist are required on a limited part-time basis, or to perform intermittent services, payment may be made on the basis of a reasonable rate per unit of service, even though this rate may be greater per unit of time than salary-related amounts, if the greater payment is, in the aggregate, less than the amount that would have been paid had a therapist been employed on a full-time or regular part-time salaried basis. Pursuant to section 17(a) of Pub. L. 93–233 (87 Stat. 967), the provisions of this section are effective for cost reporting periods beginning after March, 1975.

(b) *Definitions*—(1) *Prevailing salary.* The prevailing salary is the hourly salary rate based on the 75th percentile of salary ranges paid by providers in the geographical area, by type of therapy, to therapists working full time in an employment relationship.

(2) *Fringe benefit and expense factor.* The standard fringe benefit and expense factor is an amount that takes account of fringe benefits, such as vacation pay, insurance premiums, pension payments, allowances for job-related training, meals, etc., generally received by an employee therapist, as well as expenses, such as maintaining an office, appropriate insurance, etc., an individual not working as an employee might incur in furnishing services under arrangements.

(3) *Adjusted hourly salary equivalency amount.* The adjusted hourly salary equivalency amount is the prevailing hourly salary rate plus the standard fringe benefit and expense factor. This amount is determined on a periodic basis for appropriate geographical areas.

(4) *Travel allowance.* A standard travel allowance is an amount that is recognized, in addition to the adjusted hourly salary equivalency amount.

(5) *Limited part-time or intermittent services.* Therapy services are considered to be on a limited part-time or intermittent basis if the provider or other organization furnishing the services under arrangements requires the services of a therapist or therapists on an averge of less than 15 hours per week. This determination is made by dividing the total hours of services furnished during the cost reporting period by the number of weeks in which the services were furnished in the cost reporting period regardless of the number of days in each week in which services were performed.

(6) *Guidelines.* Guidelines are the amounts published by HCFA reflecting the application of paragraphs (b) (1) through (4) of this section to an individual therapy service and a geographical area. Other statistically valid data may be used to establish guidelines for a geographical area, provided that the study designs, questionnaires and instructions, as well as the resultant survey data for determining the guidelines are submitted to and approved in advance by HCFA. Such data must be arrayed so as to permit the determination of the 75th percentile of the range of salaries paid to full-time employee therapists.

(7) *Administrative responsibility.* Administrative responsibility is the performance of those duties that normally fall within the purview of a department head or other supervisor. This term does not apply to directing aides or other assistants in furnishing direct patient care.

(c) *Application.* (1) Under this provision, HCFA will establish criteria for use in determining the reasonable cost of physical, occupational, speech, and other therapy services and the services of other health specialists (other than physicians) furnished by individuals under arrangements with a provider of services, a clinic, a rehabilitation agency, or public health agency. It is recognized that providers have a wide variety of arrangements with such individuals. These individuals may be independent practitioners or employees of organizations furnishing various health care specialists. This provision does not require change in the substance of these arrangements.

(2) If therapy services are performed under arrangements at a provider site on a full-time or regular part-time basis, the reasonable cost of such services may not exceed the amount determined by taking into account the total number of hours of services furnished by the therapist, the adjusted hourly salary equivalency amount appropriate for the particular therapy in the geographical area in which the services are furnished and a standard travel allowance.

(3) If therapy services are performed under arrangements on a limited part-time or intermittent basis at the provider site, the reasonable cost of such services is evaluated on a reasonable rate per unit of service basis, except that payment for these services, in the aggregate, during the cost reporting period, may not exceed the amount that would be determined to be reasonable under paragraph (c)(2) of this section, had a therapist furnished the provider or other organization furnishing the services under arrangements 15 hours of service per week on a regular part-time basis for the weeks in which services were furnished by the non-employee therapist.

(4) If an HHA furnishes services under arrangements at the patient's residence or in other situations in which therapy services are not performed at the provider's site, the reasonable cost of such services is evaluated as follows:

(i) *Time records available.* If time records of HHA visits are maintained by the provider, the reasonable cost of such services is evaluated on a unit-of-time basis, by taking into account the total number of hours of service furnished by the therapist, the adjusted hourly salary equivalency amount appropriate for the particular therapy in the geographical area in which the services are furnished, and a standard travel allowance for each visit. However, if the travel time of the therapist is accurately recorded by the therapist, and approved and maintained by the provider, the reasonable cost of such services may be evaluated, at the option of the provider, by taking into account the total number of hours of service furnished by the therapist, including travel time, and the adjusted hourly salary equivalency amount appropriate for the particular therapy in the geographical area in which the services are furnished. This option does not apply to services furnished by HHAs under arrangements with providers other than HHAs.

(ii) *No time records available.* If time records are unavailable or found to be inaccurate, each HHA visit is considered the equivalent of one hour of service. In such cases, the reasonable cost of such services is determined by taking into account the number of visits made by the therapist under arrangements with such agency, the

adjusted hourly salary equivalency amount appropriate for the particular therapy in the geographical area in which the services are furnished and a standard travel allowance.

(iii) *Limited part-time or intermittent services.* If under paragraph (c)(4) (i) or (ii) of this section, the provider required therapy services on an average of less than 15 hours per week, the services are considered limited part-time or intermittent services, and the reasonable cost of such services is evaluated on a reasonable rate per unit of service basis as described in paragraph (c)(3) of this section.

(5) These provisions are applicable to individual therapy services or disciplines by means of separate guidelines by geographical area and apply to costs incurred after issuance of the guidelines but no earlier than the beginning of the provider's cost reporting period described in paragraph (a) of this section. Until a guideline is issued for a specific therapy or discipline, costs are evaluated so that such costs do not exceed what a prudent and cost-conscious buyer would pay for the given service.

(d) *Notice of guidelines to be imposed.* Prior to the beginning of a period to which a guideline will be applied, a notice will be published in the **Federal Register** establishing the guideline amounts to be applied to each geographical area by type of therapy.

(e) *Additional allowances.* (1) If a therapist supervises other therapists or has administrative responsibility for operating a provider's therapy department, a reasonable allowance may be added to the adjusted hourly salary equivalency amount by the intermediary based on its knowledge of the differential between therapy supervisors' and therapists' salaries in similar provider settings in the area.

(2) If a therapist performing services under arrangements furnishes equipment and supplies used in furnishing therapy services, the guidelines amount may be supplemented by the cost of the equipment and supplies, provided the cost does not exceed the amount the provider, as a prudent and cost-conscious buyer, would have been able to include as allowable cost.

(f) *Exceptions.* The following exceptions may be granted but only upon the provider's demonstration that the conditions indicated are present:

(1) *Exception because of binding contract.* A provider will be excepted from the provisions of this section if it has a binding contract in writing with a therapist or contracting organization entered into prior to the date guidelines are published. Before the exception may be granted, however, the provider must submit the contract to its intermediary for a determination under this paragraph, subject to review and approval by the Regional Office. Such an exception may be granted for the contract period, but not longer than one year from the date initial guidelines for the particular therapy are published.

(2) *Exception because of unique circumstances or special labor market conditions.* An exception may be granted under this section by the intermediary if a provider demonstrates that the costs for therapy services established by the guideline amounts are inappropriate to a particular provider because of some unique circumstances or special labor market conditions in the area.

(3) *Exception for services furnished by risk-basis HMO providers.* For special rules concerning services furnished to an HMO's enrollees who are Medicare beneficiaries by a provider owned or operated by a risk-basis HMO (see § 417.201(b) of this chapter) or related to a risk-basis HMO by common ownership or control (see § 417.250(c)) of this chapter.

(4) *Exception for inpatient hospital services.* Effective with cost reporting periods beginning on or after October 1, 1983, the costs of therapy services furnished under arrangements to a hospital inpatient are excepted from the guidelines issued under this section if such costs are subject to the provisions of § 413.40 or Part 412 of this chapter. The intermediary will grant the exception without request from the provider.

(g) *Appeals.* A request by a provider for a hearing on the determination of an intermediary concerning the therapy costs determined to be allowable based on the provisions of this section, including a determination with respect to an exception under paragraph (f) of this section, is made to the intermediary only after submission of its cost report and receipt of the notice of amount of program reimbursement reflecting such determination, in accordance with the provisions of Subpart R of Part 405 of this chapter.

§ 413.110 Determining allowable cost for drugs.

(a) *Principle.* (1) The allowable cost for any multiple-source drug (as described in paragraph (b)(1) of this section) may not exceed the lesser of the—

(i) Actual cost;

(ii) Amount that would be paid by a prudent and cost-conscious buyer for such drug if obtained from the lowest-priced source that is widely and consistently available (whether sold by generic or trade name); or

(iii) "Maximum allowable cost" as defined in 45 CFR 19.5(c).

(2) The allowable cost of any other drug may not exceed what a prudent and cost-conscious buyer would pay for that particular drug.

(b) *Application*—(1) *Multiple-source drugs.* (i) HHS will publish in the **Federal Register**, from time to time, a list of specific multiple-source drugs and their "maximum allowable cost" limitations. (See 45 CFR Part 19.) For these drugs, the allowable cost (see §§ 413.5 and 413.50) may not exceed the drug-ingredient costs incurred in purchasing such drugs that would be paid by a prudent and cost-conscious provider for such drugs if obtained from the lowest-priced source that is widely and consistently available (whether sold by generic or trade name); except that the drug-ingredient cost incurred in purchasing such drugs may, in no case, exceed the maximum allowable cost published in the **Federal Register.**

(ii) The provisions of this paragraph (b)(1) are applicable to those multiple-source drugs purchased by providers on or after the effective date of the final maximum allowable cost determination pursuant to 45 CFR, Part 19. Similarly, an amendment to a maximum allowable cost determination for a drug is applicable to purchases of such drug by providers on or after the effective date of the amended determination.

(2) *Other drugs.* For drugs other than those described in paragraph (b)(1) of this section, the allowable cost (see §§ 413.5 and 413.50) may not exceed what a prudent and cost-conscious buyer would pay for that particular drug.

(3) *Evaluation.* The cost of any drugs will be evaluated in terms of the quantities and purchasing arrangements at which the drugs were, in fact, purchased.

(4) *Charge to beneficiaries.* No charge may be made to the beneficiary for any amount of any drug cost not reimbursed as a result of application of the rule of this section.

(c) *Exceptions.* The following exceptions may be granted but only upon the provider's demonstration that the conditions indicated are present:

(1) *Exception because of medical necessity.* If a physician certifies that in his medical judgment a specific brand is medically necessary for a particular patient, the provisions of paragraph (b)(1) of this section will not apply. However, the physician must certify in his own handwriting the medical necessity for the exception. An example

of an acceptable statement would be, "This band is medically necessary—dispense as written." Merely checking a box on a form will not constitute an acceptable certification. The provider must retain such certification in its records.

(2) *Exception for risk-basis HMO providers.* For special rules concerning providers owned or operated by a risk-basis HMO, or related to a risk-basis HMO by common ownership or control, see § 417.250(c).

(d) *Appeals*—(1) *Amount of reimbursement.* A provider may appeal the amount of reimbursement determined under this section (see Subpart R of Part 405 of this chapter) except that it may not appeal under that subpart the—

(i) Inclusion of any multiple-source drugs on the published listing; or

(ii) Established maximum allowable cost for any drug.

(2) *Inclusion on listing or maximum allowable cost.* The procedures covering the issues described in paragraphs (d)(1)(i) and (d)(1)(ii) of this section are set forth in 45 CFR Part 19.

§ 413.114 Reasonable cost of extended care services furnished by a swing-bed hospital.

(a) *Purpose and basis.* This section implements section 1883 of the Act, which provides for reimbursement for extended care services furnished by small, rural hospitals having a swing-bed approval. Payments to such hospitals for extended care services furnished in general routine inpatient beds are based on the reasonable cost of extended care services, in accordance with paragraph (c) of this section.

(b) *Definition.* A swing-bed hospital is a hospital participating in Medicare that has an approval from HCFA to provide extended care services as defined in § 409.20 of this chapter, and meets the requirements specified in § 482.66 of this chapter.

(c) *Principle.* The reasonable cost of extended care services furnished by a swing-bed hospital is determined as follows:

(1) If a hospital is located in a State participating in Medicaid, the reasonable cost of the routine services is based on the average Statewide rate per patient day paid under the State Medicaid plan for routine services furnished by SNFs in that State during the previous calendar year. The Statewide average rate will be computed either by——

(i) The State and furnished to HCFA; or

(ii) HCFA directly based on the best available data.

(2) If a hospital is located in a State that is not participating in Medicaid, the reasonable cost of the routine services is based on the average reasonable cost per patient day under Medicare for routine services furnished by SNFs in that State during the previous calendar year. HCFA will determine the average reasonable cost using Medicare cost reports, with adjustments to account for cost reporting periods not covering the calendar year preceding the year for which the rate is to be effective.

(3) The reasonable cost of ancillary services furnished as extended care services is determined in the same manner as the reasonable cost of other ancillary services furnished by the hospital in accordance with § 413.55(a)(1).

Subpart G—Capital-Related Costs

§ 413.130 Introduction to capital-related costs.

(a) *General rule.* Capital-related costs and an allowance for return on equity are limited to the following:

(1) Net depreciation expense as determined under §§ 413.134, 413.144, and 413.149, adjusted by gains and losses realized from the disposal of depreciable assets under § 413.134(f).

(2) Taxes on land or depreciable assets used for patient care.

(3) Leases and rentals, including license and royalty fees, for the use of depreciable assets, as described in paragraph (b) of this section.

(4) The costs of betterments and improvements as described in paragraph (c) of this section.

(5) The costs of minor equipment that are capitalized, rather than expensed, as described in paragraph (d) of this section.

(6) Insurance expense on depreciable assets, as described in paragraph (e) of this section.

(7) Interest expense as determined under § 413.153, subject to the qualifications of paragraph (f) of this section.

(8) For proprietary providers, return on equity capital, as determined under § 413.157.

(9) The capital-related costs of related organizations (as described in § 413.17, as determined in accordance with paragraph (g) of this section.

(b) *Leases and rentals.* (1) Subject to the qualifications of paragraphs (b) (2) and (4) of this section, leases and rentals, including licenses and royalty fees, are includable in capital-related costs if they relate to the use of assets that would be depreciable if the provider owned them outright. The terms "leases" and "rentals of assets" signify that a provider has possession, use, and enjoyment of the assets.

(2) A provider must include incurred rental charges in its capital-related costs, as specified in a sale and leaseback agreement with a nonrelated purchaser (including shared service organizations not related within the meaning of § 413.17) involving plant facilities or equipment, only if the following conditions are met:

(i) The rental charges are reasonable based on—

(A) Consideration of rental charges of comparable facilities and market conditions in the area;

(B) The type, expected life, condition, and value of the facilities or equipment rented; and

(C) Other provisions of the rental agreements.

(ii) Adequate alternate facilities or equipment that would serve the purpose are not or were not available at lower cost.

(iii) The leasing was based on economic and technical considerations.

(3) If the conditions of paragraph (b)(2) of this section are not met, the amount a provider may include in its capital-related costs as rental or lease expense under a sale and leaseback agreement may not exceed the amount that the provider would have included in its capital-related costs had the provider retained legal title to the facilities or equipment, such as interest on mortgage, taxes, depreciation, and insurance costs.

(4) A lease that meets the following conditions generally establishes a virtual purchase:

(i) The rental charge exceeds rental charges of comparable facilities or equipment in the area.

(ii) The term of the lease is less than the useful life of the facilities or equipment.

(iii) The provider has the option to renew the lease at a significantly reduced rental, or the provider has the right to purchase the facilities or equipment at a price that appears to be significantly less than what the fair market value of the facilities or equipment would be at the time acquisition by the provider is permitted.

(5)(i) If a lease is a virtual purchase under paragraph (b)(4) of this section, the rental charge is includable in capital-related costs only to the extent that it does not exceed the amount that the provider would have included in capital-related costs if it had legal title to the asset (the cost of ownership), such as straight-line depreciation, insurance, and interest. A provider may not include in its capital-related costs accelerated depreciation in this situation.

(ii) The difference between the amount of rent paid and the amount of rent allowed as capital-related costs is considered a deferred charge and is capitalized as part of the historical cost of the asset when the asset is purchased.

(iii) If an asset is returned to the owner, instead of being purchased, the deferred charge may be included in capital-related costs in the year the asset is returned.

(iv) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase still exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental to an amount not in excess of the cost of ownership.

(v) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase no longer exists, the deferred charge may be included in the capital-related costs to the extent of increasing the reduced rental to a fair rental value.

(c) *Betterments and improvements.*

(1) Betterments and improvements are changes which extend the estimated useful life of an asset at least two years beyond its original estimated useful life, or increase the productivity of an asset significantly over its original productivity.

(2) A provider must capitalize and pro-rate the costs of betterments and improvements over the remaining estimated useful life of the asset, as modified by the betterment or improvement.

(d) *Minor equipment.* A provider must include in its capital-related costs the costs of minor equipment that are capitalized rather than charged off to expense if—

(1) The net book value of minor equipment at the time the provider enters the program is prorated over three years (that is, one-third of the net book value is written off each year), and new purchases are also prorated over a 3-year period; or

(2) The cost of minor equipment is prorated over their actual useful lives.

(e) *Insurance.* (1) A provider must include in its capital-related costs the costs of insurance on depreciable assets used for patient care or insurance that provides for the payment of capital-related costs during business interruption.

(2) If an insurance policy also provides protection for other than the replacement of depreciable assets or to pay capital-related costs in the case of business interruption insurance, only that portion of the premium related to the replacement of depreciable assets or to pay capital-related costs in the case of business interruption insurance is includable in capital-related costs.

(f) *Interest expense.* (1) A provider must include in its capital-related costs interest expense, as described in § 413.153, if such expense is incurred in—

(i) Acquiring land or depreciable assets (either through purchase or lease) used for patient care; or

(ii) Refinancing existing debt, if the original purpose of the refinanced debt was to acquire land or depreciable assets used for patient care.

(2) If investment income offset is required under § 413.153(b)(2)(iii), only that portion of investment income that bears the same relationship to total investment income, as the portion of capital-related interest expense bears to total interest expense, is offset against capital-related costs.

(g) *Costs of supplying organizations—*

(1) *Supplying organizations related to the provider.* (i) If the supplying organization is related to the provider within the meaning of § 413.17, except as provided in paragraph (g)(1)(ii) of this section, a provider's capital-related costs include the capital-related costs of the supplying organization.

(ii) If the costs of the services, facilities or supplies being furnished exceed the open market price, or if the provisions of § 413.17(d) apply, no part of the cost to the provider of the services, facilities, or supplies are considered capital-related costs, unless the services, facilities, or supplies would otherwise be considered capital-related.

(2) *Supplying organizations not related to the provider.* If the supplying organization is not related to the provider within the meaning of § 413.17, no part of the charge to the provider may be considered a capital-related cost (unless the services, facilities, or supplies are capital-related in nature) unless—

(i) The capital-related equipmente is leased or rented (as described in paragraph (b) of this section) by the provider;

(ii) The capital-related equipment is located on the provider's premises, or is located offsite and is on real estate owned, leased or rented by the provider; and

(iii) The capital-related portion of the charge is separately specified in the charge to the provider.

(h) *Costs excluded from capital-related costs.* The following costs are not capital-related costs. To the extent that they are allowable, they must be included in determining each provider's operating costs:

(1) Costs incurred for the repair or maintenance of equipment or facilities.

(2) Amounts included in rentals or lease payments for repair or maintenance agreements.

(3) Interest expense incurred to borrow working capital (for operating expenses).

(4) General liability insurance or any other form of insurance to provide protection other than for the replacement of depreciable assets or to pay capital-related costs in the case of business interruption.

(5) Taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care. (Taxes not related to patient care, such as income taxes, are not allowable, and are therefore not included among either capital-related or operating costs.)

(6) The costs of minor equipment that are charged off to expense rather than capitalized as described in paragraph (d) of this section.

§ 413.134 Depreciation: Allowance for depreciation based on asset costs.

(a) *Principle.* An appropriate allowance for depreciation on buildings and equipment used in the provision of patient care is an allowable cost. The depreciation must be—

(1) Identifiable and recorded in the provider's accounting records;

(2) Based on the historical cost of the asset or fair market value at the time of donation in the case of donated assets; and

(3) Prorated over the estimated useful life of the asset using—

(i) The straight-line method; or

(ii) Accelerated depreciation under a declining balance method (not to exceed double the straight-line rate) or the sum-of-the-years' digits method in the following situations:

(A) Depreciable assets for which accelerated depreciation was used for Medicare purposes before August 1, 1970, including those assets for which a timely request to change from straight-line depreciation to accelerated depreciation was received by an intermediary before August 1, 1970;

(B) Depreciable assets acquired before August 1, 1970, if no election to use straight-line or accelerated depreciation was in effect on August 1, 1970; and the provider was participating in the program on August 1, 1970;

(C) Depreciable assets of a provider if construction of such depreciable asset began before February 5, 1970, and the provider was participating in the program on February 5, 1970; or

(D) Depreciable assets of a provider if a valid written contract was entered into by a provider participating in the program before February 5, 1970, for

construction, acquisition, or for the permanent financing thereof, and such contract was binding on a provider on February 5, 1970, and at all times thereafter; or

(iii) A declining balance method, not to exceed 150 percent of the straight-line rate, for a depreciable asset acquired after July 31, 1970; however, this declining balance method may be used only if the cash flow from depreciation on the total assets of the institution during the reporting period, including straight-line depreciation on the assets in question, is insufficient (assuming funding of available capital not required currently for amortization and assuming reasonable interest income on such funds) to supply the funds required to meet the reasonable principal amortization schedules on the capital debts related to the provider's total depreciable assets. For each depreciable asset for which a provider requests authorization to use a declining balance mehod for Medicare reimbursement purposes, but not to exceed 150 percent of the straight-line rate, the provider must demonstrate to the intermediary's satisfaction that the required cash flow need exists. For each depreciable asset in which a provider justifies the use of accelerated depreciation, the intermediary must give written approval for the use of a depreciation method other than straight-line before basing any interim payment on this accelerated depreciation or making its reasonable cost determination which includes an allowance from such depreciation.

(b) *Definitions*—(1) *Historical costs.* Historical cost is the cost incurred by the present owner in acquiring the asset. For depreciable assets acquired after July 31, 1970, the historical cost may not exceed the lower of current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of the purchase, or fair market value at the time of the purchase.

(2) *Fair market value.* Fair market value is the price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition. Usually the fair market price is the price that bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition.

(3) *The straight-line method.* Under the straight-line method of depreciation, the cost or other basis (for example, fair market value in the case of donated assets) of the asset, less its estimated salvage value, if any, is determined first. Then this amount is distributed in equal amounts over the period of the estimated useful life of the asset.

(4) *Declining balance method.* Under the declining balance method, the annual depreciation allowance is computed by multiplying the undepreciated cost of the asset each year by a uniform rate up to double the straight-line rate or 150 percent, as the case may be (see paragraph (a)(3) of this section for limitations on use of accelerated methods of depreciation).

(5) *Sum-of-the-years' digits method.* Under the sum-of-the-years' digits method, the annual depreciation allowance is computed by multiplying the depreciable cost basis (cost less salvage value) by a constantly decreasing fraction. The numerator of the fraction is represented by the remaining years of useful life of the asset at the beginning of each year, and the denominator is always, represented by the sum of the years' digits of useful life at the time of acquisition.

(6) *Current reproduction cost.* Current reproduction cost is the cost at current prices, in a particular locality or market area, of reproducing an item of property or a group of assets. Where depreciable assets are concerned, this means the reasonable cost to have built, reproduce in kind, or, in the case of equipment or similar assets, to purchase in the competitive market.

(7) *Useful life.* The estimated useful life of a depreciable asset is its normal operating or service life to the provider, subject to the provisions in paragraph (b)(7)(i) of this section. Factors to be considered in determining useful life include normal wear and tear, obsolescene due to normal economic and technological changes; climatic and other local conditions; and the providers' policy for repairs and replacement.

(i) *Initial selection of useful life.* In selecting a proper useful life for computing depreciation under the Medicare program providers must use the useful life guidelines published by HCFA. If HCFA has not published applicable useful life guidelines, providers must use—

(A) The edition of the American Hospital Association useful life guidelines, as specified in HCFA Medicare program manuals; or

(B) A different useful life specifically requested by the provider and approved by the intermediary. A different useful life may be approved by the intermediary if the provider's request is properly supported by acceptable factors that affect the determination of useful life. However, such factors as an expected early sale, retirement, demolition or abandonment of an asset, or termination of the provider from the Medicare program may not be used.

(ii) *Application of guidelines.* The provisions concerning the selection of useful life guidelines described in paragraph (b)(7)(i) of this section apply to assets acquired on or after January 1, 1981. For assets acquired before January 1, 1981, providers must use the useful life guidelines published by the American Hospital Association in its 1973 edition of *Chart of Accounts for Hospitals*, or those published by the Internal Revenue Service, or those approved for use by intermediaries as provided in paragraph (b)(7)(i)(B) of this section.

(iii) *Changing useful life.* A change in the estimated useful life may be made if clear and convincing evidence justifies a redetermination of the useful life used by the provider. Such a change must be approved by the intermediary in writing, and the factors cited in paragraph (b)(7) and (b)(7)(i) of this section are applicable in making such redeterminations of useful life. If the request is approved the change is effective with the reporting period immediately following the period in which the provider's request is submitted for approval.

(c) *Recording of depreciation.* Appropriate recording of depreciation includes the identification of the depreciable assets in use, the assets' historical costs, the assets' dates of acquisition, the method of depreciation, estimated useful lives, and the assets' accumulated depreciation.

(d) *Depreciation methods*—(1) *General.* Proration of the cost of an asset over its useful life is allowed on the straight-line method, or, where permitted under § 413.134(a)(3), the declining balance or the sum-of-the-years' digits methods. One method may be used on a single asset or group of assets and another method on others. In applying the declining balance or sum-of-the-years' digits method to an asset that is not new, the undepreciated cost of the asset is treated as the cost of a new asset in computing depreciation.

(2) *Change in method.* Prior to August 1, 1970, a provider may change from the straight-line method to an accelerated method or vice versa, upon advance approval from the intermediary on a prospective basis with the request being made before the end of the first month of the prospective reporting period. Only one such change with respect to a particular asset may be made by a provider. Effective with August 1, 1970, a provider may only change from an accelerated method or optional method (see § 413.139) to the straight-line

method. Such a change may be made without intermediary approval and the basis for depreciation is the undepreciated cost reduced by the salvage value. Thereafter, once straight-line depreciation is selected for a particular asset, an accelerated method may not be established for that asset.

(3) *Recovery of accelerated depreciation*—(i) *General.* If a provider who has used an accelerated method of depreciation for any of its assets terminates participation in the program, or if the Medicare proportion of its allowable costs decreases so that cumulatively substantially more depreciation was paid than would have been paid using the straight-line method of depreciation, the excess of reimbursable cost determined by using accelerated depreciation methods and paid under the program over the reimbursable cost that would have been determined and paid under the program by using the straight-line method of depreciation will be recovered as an offset to current reimbursement due or, if the provider has terminated participation in the program, as an overpayment. In this determination of excess payment, recognition will be given to the effects the adjustment to straight-line depreciation would have on the return on equity capital and on the allowance in lieu of specific recognition of other costs in the respective years.

(ii) *Transaction between related organizations*—(A) *General.* If the termination of the provider agreement is due to a change in provider ownership, as defined in § 489.18, resulting from a transaction between related organizations, as defined in § 413.17, and the criteria in paragraph (b) of this section are met, the excess of reimbursable cost, as determined in paragraph (d)(3)(i) of this section may not be recovered if there is a continuation of participation by the facility in the Medicare program.

(B) *Criteria.* The following criteria must be met if the recovery of excess reimbursable cost is not to be made:

(*1*) The termination of the provider agreement is due to a change in ownership of the provider resulting from a transaction between related organizations.

(*2*) The successor provider continues to participate in the Medicare program.

(*3*) Control and the extent of the financial interest of the owners of the provider before and after the termination remain the same; that is, the successor owners acquire the same percentage of control or financial investment as the transferors had.

(*4*) All assets and liabilities of the terminated provider are transferred to the related successor participating provider.

(C) *Effect of transaction.* In transactions meeting the criteria specified in paragraph (d)(3)(ii)(B) of this section, the provision concerning recovery of excess reimbursable cost (§413.134(d)(3)(i)) is not applied, and the transaction is treated as follows:

(*1*) The successor provider must record the historical cost and accumulated depreciation and the method of depreciation recognized under the Medicare program, and these are considered as incurred by the successor provider for Medicare purposes.

(*2*) The Medicare program's utilization of the terminated provider is considered as having been incurred by the successor provider for Medicare purposes.

(*3*) The equity capital of the terminated provider as of the closing of its final cost reporting period must be wholly contained in the equity capital of the successor provider as of the beginning of its first cost reporting period.

(e) *Funding of depreciation.* Although funding of depreciation is not required, it is strongly recommended that providers use this mechanism as a means of conserving funds for replacement of depreciable assets, and coordinate their planning of capital expenditures with areawide planning activities of community and State agencies. As an incentive for funding, investment income on funded depreciation will not be treated as a reduction of allowable interest expense.

(f) *Gains and losses on disposal of assets*—(1) *General.* Depreciable assets may be disposed of through sale, scrapping, trade-in, exchange, demolition, abandonment, condemnation, fire, theft, or other casualty. If disposal of a depreciable asset results in a gain or loss, an adjustment is necessary in the provider's allowable cost. The amount of a gain included in the determination of allowable cost is limited to the amount of depreciation previously included in Medicare allowable costs. The amount of a loss to be included is limited to the undepreciated basis of the asset permitted under the program. The treatment of the gain or loss depends upon the manner of disposition of the asset, as specified in paragraphs (f)(2) through (f)(6) of this section.

(2) *Bona fide sale or scrapping.* (i) Except as specified in paragraph (f)(3) of this section gains and losses realized from the bona fide sale or scrapping of depreciable assets are included in the determination of allowable cost only if the sale or scrapping occurs while the provider is participating in Medicare. The extent to which such gains and losses are included is calculated by prorating the basis for depreciation of the asset in accordance with the proportion of the asset's useful life for which the provider participated in Medicare. For purposes of this paragraph (f)(2)(i), scrapping refers to the physical removal from the provider's premises of tangible personal properties that are no longer useful for their intended purpose and are only salable for their scrap or junk value.

(ii) If the total amount of gains or losses realized from bona fide sales or scrapping does not exceed $5,000 within the cost reporting period or if the provider's cumulative utilization under the Medicare program is less than 5 percent, the net amount of gains or losses realized from sale or scrapping will be allowed as a depreciation adjustment in the period of disposal. For purposes of this paragraph (f)(2)(ii), the provider's cumulative Medicare utilization precentage is determined by comparing the cumulative total of the Medicare inpatient days for all reporting periods in which depreciation on the asset disposed of was claimed under the Medicare program to the cumulative total of inpatient days of the participating provider for the same reporting periods.

(iii) If the conditions specified in paragraph (f)(2)(ii) of this section are not met, the adjustment to reimbursable cost in the reporting period of asset disposition is calculated as follows:

(A) The total amount of gains or losses shall be allocated to all reporting periods under the Medicare program, based on the ratio of the depreciation allowed on the assets in each reporting period to the total depreciation allowed under the Medicare program.

(B) The results of this allocation are multiplied by the ratio of Medicare reimbursable cost to total allowable cost for each reporting period.

(C) The results of this multiplication are then added.

(iv) If a provider sells more than one asset for a lump sum sale price, the gain or loss on the sale of each depreciable asset must be determined by allocating the lump sum sales price among all the assets sold, in accordance with the fair market value of each asset as it was used by the provider at the time of sale. If the buyer and seller cannot agree on an allocation of the sales price, or if they do agree but there is insufficient documentation of the current fair market value of each asset, the intermediary for the selling provider will require an

appraisal by an independent appraisal expert to establish the fair market value of each asset and will make an allocation of the sales price in accordance with the appraisal.

(3) *Sale within 1 year after termination.* Gains and losses realized from a bona fide sale of depreciable assets within 1 year immediately following the date on which the provider terminates participation in the Medicare program are also included in the determination of allowable cost, in accordance with the procedure specified in paragraph (f)(2) of this section. However, if several assets are sold for a lump sum sales price, the determination of fair market value must be based on the appraised value of the assets as they were last used by the provider while participating in the Medicare program.

(4) *Exchange or trade-in.* Gains or losses realized from the exchange or trade-in of depreciable assets are not included in the determination of allowable cost. When the disposition of an asset is by means of exchange or trade-in, the historical cost of the new asset is the sum of the undepreciated cost of the asset disposed of and the additional cash or other assets transferred or to be transferred to acquire the new asset. However, if the asset disposed of was acquired by the provider before its participation in the Medicare program and the sum of the undepreciated cost and the cash or other assets transferred or to be transferred exceed the list price or fair market value of the new asset, the historical cost of the new asset is limited to the lower of its list price or fair market value.

(5) *Demolition or abandonment.* (i) For purposes of this section, the term "abandonment" means the permanent retirement of an asset for any future purpose, not merely the provider's ceasing to use the asset for patient care purposes. To claim an abandonment under the Medicare program, the provider must have relinquished all rights, title, claim, and possession of the asset with the intention of never reclaiming it or resuming its ownership, possession, or enjoyment.

(ii) If losses resulting from the demolition or abandonment of depreciable assets do not exceed $5,000 within the cost-reporting period, the losses are to be allowed in the period of disposal.

(iii) If losses exceed $5,000 and, at the date of disposition, the demolished or abandoned assets are at least 80 precent depreciated as computed under the straight-line method, such losses are includable in the determination of allowable cost under the Medicare program in the period of disposal and the procedure provided in paragraph (f)(2)(iii) of this section must be used in determining the adjustment to reimbursable cost.

(iv) Losses in excess of $5,000 resulting from the demolition or abandonment of assets, which at the date of disposition are not 80 percent depreciated as computed under the straight-line method, must be capitalized as a deferred charge and amortized as follows:

(A) If the State Health Planning and Development Agency (SHPDA) designated under section 1521 of the Public Health Service Act approves the demolition or abandonment of a depreciable asset as being consistent with the health systems plan of the health service area in which the provider is located, the net loss realized shall be capitalized as a deferred charge and amortized over the remaining life of the demolished or abandoned asset, or at the rate of $5,000 per year, whichever is greater. If no SHPDA exists or if such agency is unable or unwilling to perform this function, the provider must submit a request for approval to the intermediary. The intermediary, after reviewing this request and before issuing the approval, will submit the request along with its recommendation to the appropriate regional office for its approval.

(B) If a provider fails to obtain approval as specified in paragraph (f)(5)(iv)(A) of this section, a loss is not allowable unless the demolished or abandoned assist is replaced. If the asset is replaced, the loss resulting from the unapproved demolition or abandonment must be capitalized as a deferred charge and amortized over the estimated useful life of the replacement asset or at the rate of $5,000 per year, whichever is greater.

(v) If a loss resulting from the demolition or abandonment is deferred and amortized and the provider terminates its participation in the Medicare program or ceases to use a replacement asset in the provision of patient care services, the unamortized deferred charge remaining at that time must not be included in determining allowable cost under the Medicare program.

(vi) Losses on demolition must include the demolition cost incurred by the provider for razing and removal of the asset, less any salvage value recovered by the provider. However, if a provider demolishes a depreciable asset for the purpose of preparing land for future sale, the net demolition cost incurred by the provider (razing and removal cost less salvage recovered) is considered a capital expenditure and added to the historical basis of the land.

(vii) If a provider purchases land on which there is a building, no depreciation will be allowed under the Medicare program unless the building is used in providing patient care. If the building is demolished, the entire purchase price and demolition cost shall be considered the historical cost of the land. If the building is used for patient care, but demolished within 5 years of purchase, the entire purchase price, less allowed depreciation, plus demolition cost will be considered the historical cost of the land.

(6) *Involuntary conversion.* (i) Losses resulting from the involuntary conversion of depreciable assets, such as condemnation, fire, theft, or other casualty, are generally included in the determination of allowable cost on a deferred basis if the asset is restored or replaced. However, losses resulting from a provider's imprudent management of its depreciable assets, such as the failure to obtain proper insurance coverage, are not included in the determination of allowable cost.

(ii) The net allowable loss from involuntary conversion must consist of the undepreciated cost of unrecovered book value of the asset, less amounts received from insurance proceeds gifts and grants received from local, State, or Federal Government, or any other source as a result of the involuntary conversion.

(iii) If the asset is replaced and the net allowable loss in any cost-reporting period does not exceed $5,000, the entire amount must be included in allowable cost in the period in which the loss is incurred. If the asset is replaced and the net allowable loss in any cost-reporting period exceeds $5,000, the loss must be capitalized as a deferred charge and amortized over the useful life of the replacement or restored asset. If a replaced or restored asset ceases to be used in the provision of patient care services or the provider terminates its participation in the Medicare program, the unamortized deferred charge remaining at that time will not be included in determining allowable cost under the Medicare program.

(iv) If the provider fails to replace or restore an involuntarily converted asset, the loss is not included in determining allowable cost. However, if the provider intends to replace or restore the asset but is unable to do so because the designated SHPDA finds such replacement or restoration to be inconsistent with the health systems plan of the provider's health service area, the loss is allowable so long as the provider continues to participate in Medicare. In this case, the loss must be

capitalized as a deferred charge and amortized over the remaining life of the involuntarily converted asset, or at the rate of $5,000 per year, whichever is greater.

(v) If a gain is realized from an involuntary conversion of depreciable assets, the net amount realized reduces the basis of the restored or replacement asset. If the asset is not restored or replaced, the gain is to be treated in accordance with paragraph (f)(2) of this section.

(7) *Effect on equity capital.* The unrecovered loss entered on the books of the provider as a deferred charge, in accordance with paragraphs (f) (5) and (6) of this section, is not includable in the computation of equity capital under § 413.157.

(8) *Sale of replacement or restored assets.* If a provider sells a replacement or restored asset while participating in the Medicare program or within 1 year immediately following the date on which it terminates its participation in the Medicare program, the unrecovered loss entered on the books of the provider as a deferred charge in accordance with paragraphs (f) (5) and (6) of this section will not be included in determining the gain or loss realized from the sale of the replacement or restored asset. However, if the sale of such asset is made to a related organization, as defined in § 413.17, and the purchasing organization continues as a provider in the Medicare program, the remaining deferred charge representing the unrecovered depreciable basis of the demolished, abandoned or destroyed asset must continue to be amortized over the remaining expected useful life of the replacement or restored asset. If the sale is made to an unrelated organization, further amortization of the deferred charge is not allowed.

(g) *Establishment of cost basis on purchase of facility as an ongoing operation*—(1) *Assets acquired after July 1, 1966 and before August 1, 1970.* The cost basis for the assets of a facility purchased as an ongoing operation after July 1, 1966, and before August 1, 1970, is the lowest of the—

(i) Total price paid for the facility by the purchaser, as allocated to the individual assets of the facility;

(ii) Total fair market value of the facility at the time of the sale, as allocated to the individual assets; or

(iii) Combined fair market value of the individually identified assets at the time of the sale.

(2) *Assets acquired after July 31, 1970.* For depreciable assets acquired after July 31, 1970, in addition to the limitations specified in paragraph (g)(1) of this section, the cost basis of the depreciable assets may not exceed the current reproduction cost depreciated on a straight-line basis over the life of the assets to the time of the sale.

(3) *Transactions other than bona fide.* If the purchaser cannot demonstrate that the sale was bona fide, in addition to the limitations specified in paragraphs (g) (1) and (2) of this section, the purchaser's cost basis may not exceed the seller's cost basis, less accumulated depreciation.

(h) *Intergovernmental transfer of facilities.* The basis for depreciation of assets transferred under appropriate legal authority from one governmental entity to another is as follows:

(1) The historical cost incurred by the present owner in acquiring the asset under a bona fide sale. The historical cost may not exceed the lower of current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of the purchase of fair market value at the time of the purchase.

(2) The fair market value at the time of donation under a bona fide donation of the asset (subject to the limitations set forth under paragraph (i) of this section). An asset is considered donated when a governmental entity acquires the asset without assuming the functions for which the transferor used the asset or making any payment for it in the form of cash, property, or services.

(3) If neither paragraph (h) (1) nor (2) of this section applies, for example, the transfer was solely to facilitate administration or to reallocate jurisdictional responsibility, or the transfer constituted a taking over in whole or in part of the function of one governmental entity by another governmental entity, the basis for depreciation is—

(i) With respect to an asset on which the transferor has claimed depreciation under the Medicare program, the transferor's basis under the Medicare program prior to the transfer. The method of depreciation used by the transferee may be the same as that used by the transferor, or the transferee may change the method, as permitted under paragraph (d)(2) of this section; or

(ii) With respect to an asset on which the transferor has not claimed depreciation under the Medicare program, the cost incurred by the transferor in acquiring the asset (not to exceed the basis that would have been recognized had the transferor participated in the Medicare program) less depreciation calculated on the straight-line basis over the life of the asset to the time of transfer.

(i) *Basis of assets used under the program and donated to a provider.* If an asset that has been used or depreciated under the program is donated to a provider, the basis of depreciation for the asset is the lesser of the fair market value or the net book value of the asset in the hands of the owner last participating in the program. The net book value of the asset is defined as the depreciable basis used under the program by the asset's last participating owner less the depreciation recognized under the program.

(j) *Limitation on Federal participation for capital expenditures.* The allowance for depreciation is not an allowable cost for certain capital expenditures as described in § 413.161.

(k) *Transactions involving a provider's capital stock*—(1) *Acquisition of capital stock of a provider.* If the capital stock of a provider is acquired, the provider's assets may not be revalued. For example, if Corporation A purchases the capital stock of Corporation B, the provider, Corporation B continues to be the provider after the purchase and Corporation A is merely the stockholder. Corporation B's assets may not be revalued.

(2) *Statutory merger.* A statutory merger is a combination of two or more corporations under the corporation laws of the State, with one of the corporations surviving. The surviving corporation acquires the assets and liabilities of the merged corporation(s) by operation of State law. The effect of a statutory merger upon Medicare reimbursement is as follows:

(i) *Statutory merger between unrelated parties.* If the statutory merger is between two or more corporations that are unrelated (as specified in § 413.17), the assets of the merged corporation(s) acquired by the surviving corporation may be revalued in accordance with paragraph (g) of this section. If the merged corporation was a provider before the merger, then it is subject to the provisions of paragraphs (d)(3) and (f) of this section concerning recovery of accelerated depreciation and the realization of gains and losses. The basis of the assets owned by the surviving corporation are unaffected by the transaction. An example of this type of transaction is one in which Corporation A, a nonprovider, and Corporation B, the provider, are combined by a statutory merger, with Corporation A being the surviving corporation. In such a case the assets of Corporation B acquired by Corporation A may be revalued in accordance with paragraph (g) of this section.

(ii) *Statutory merger between related parties.* If the statutory merger is between two or more related corporations (as specified in § 413.17), no revaluation of assets is permitted for those assets acquired by the surviving corporation. An example of this type of transaction is one in which Corporation A purchase the capital stock of Corporation B, the provider. Immediately after the acquisition of the capital stock of Corporation B, there is a statutory merger of Corporation B and Corporation A, with Corporation A being the surviving corporation. Under these circumstances, at the time of the merger the transaction is one between related parties and is not a basis for revaluation of the provider's assets.

(3) *Consolidation.* A consolidation is the combination of two or more corporations resulting in the creation of a new corporate entity. If at least one of the original corporations is a provider, the effect of a consolidation upon Medicare reimbursement for the provider is as follows:

(i) *Consolidation between unrelated parties.* If the consolidation is between two or more corporations that are unrelated (as specified in § 413.17), the assets of the provider corporation(s) may be revalued in accordance with paragraph (g) of this section.

(ii) *Consolidation between related parties.* If the consolidation is between two or more related corporations (as specified in § 413.17), no revaluation of provider assets is permitted.

§ 413.139 Depreciation: Optional allowance for depreciation based on a percentage of operating costs.

(a) *Principle.* With respect to all assets acquired before 1966, the provider, at its option, may choose an allowance for depreciation based on a percentage of operating costs. The operating costs to be used are the provider's 1965 operating costs or the provider's current year's allowable costs, whichever are the lower. The percentage to be applied is 5 percent starting with the year 1966–67, with such percentage being uniformly reduced by one-half percent each succeeding year. The allowance based on operating costs is in addition to regular depreciation on assets acquired after 1965; however, if the optional allowance is selected, the combined amount of such allowance on pre-1966 assets and the straight-line depreciation on assets acquired after 1965 (including the estimated depreciation on assets held on a rental basis during the current year) may not exceed 6 percent of the provider's allowable cost for the current year.

(b) *Definitions*—(1) *Operating costs.* Operating costs are the total costs incurred by the provider in operating the institution or facility.

(2) *Allowable costs.* Allowable costs are the costs of a provider that are includable under the principles for cost reimbursement. Through application of apportionment methods to the total amount of such allowable costs, the share of a provider's total cost that is attributable to covered services for beneficiaries is determined.

(c) *Application.* If a provider has inadequate historical cost records for pre-1966 depreciable assets, the provider may elect to receive an allowance for depreciation on such assets based on a percentage of operating costs. The optional allowance for depreciation for such assets may be used, however, whether or not a provider has records of the cost of pre-1966 depreciable assets currently in use.

(d) *Allowance based on a percentage of operating costs.* (1) The allowance for depreciation based on a percentage of operating costs is to be computed by applying a specified percentage to a base amount equal to the provider's 1965 total operating costs, without adjustments to these principles or the current year's allowable operating costs, whichever is lower. The percentage to be applied is five for the reporting period that starts before or during 1966–67, four and one-half for the reporting period that begins during 1967–68, and continues to decline annually by equal amounts to become zero in 1976–77.

(2) If used as a base for determining the optional allowance for depreciation, neither the 1965 operating costs nor the current year's allowable costs are to include any actual depreciation, estimated depreciation on rented depreciable-type assets, allowance in lieu of specific recognition of other costs, or return on equity capital. Such exclusions are to be made only for the purpose of computing the allowance for depreciation based on operating costs. For other purposes, the excluded amounts are recognized in determining allowable costs and for computing the costs of services furnished to Medicare beneficiaries during the reporting period.

(e) *Change to actual depreciation.* (1) A provider that elects this allowance may at any time before 1976 change to actual depreciation on all pre-1966 depreciable assets. In such case, this option is eliminated and the provider can no longer elect to receive an allowance for depreciation based on a percentage of operating costs.

(2) If the provider desires to change to actual depreciation but either has no historical cost records or has incomplete records, the determination of historical cost may be made through appropriate means involving expert consultation with the determination being subject to review and approval by the intermediary.

(f) *Determination of optional allowance based on percentage of operating costs illustrated.* The following illustrates how the provider would determine the optional allowance for depreciation based on operating costs.

Example No. 1. The provider keeps its records on a calendar year basis. The current year's actual allowable cost and the actual operating cost for 1965 do not include any actual depreciation or rentals on depreciable-type assets. The current year's allowable cost also does not include any allowance in lieu of specific recognition of other costs or return on equity capital.

YEAR 1966

Current year's allowable cost	$1,100,000
Operating cost to 1965[1]	$1,000,000
Percent for determining the allowance	5
Allowance	$50,000

[1] 1965 Operating cost was used in computing the allowance for depreciation based on a percentage of operating costs because it was lower than 1966 allowable cost.

YEAR 1967

Current year's allowable cost	$1,200,000
Operating cost to 1965[1]	$1,000,000
Percent for determining the allowance[2]	5
Allowance	$50,000

[1] 1965 Operating cost was used in computing the allowance for depreciation based on a percentage of operating costs because it was lower than 1967 allowable cost.
[2] Since the reporting period began during the year 1966–1967 (July 1, 1966–June 30, 1967) 5 percent is the percentage to be used.

YEAR 1968

Operating cost to 1965	$1,000,000
Current year's allowable cost[1]	$900,000
Percent for determining the allowance[2]	4½
Allowance	$40,500

[1] The current year's allowable cost was used in computing the allowance for depreciation based on percentage of operating costs because it was lower than 1965 operating cost.
[2] Since the reporting period began during the year 1967–1968 (July 1, 1967–June 30, 1968) 4½ percent is the percentage to be used.

Example No. 2. When the provider pays rent for depreciable-type assets rented prior to 1966, the estimated depreciation on such assets must be deducted from the allowance. The following illustration demonstrates how the allowance is determined.

The provider keeps its records on a calendar year basis. The current year's actual allowable cost and the actual operating cost for 1965 did not include any actual depreciation, allowance in lieu of specific recognition of other costs, or return on equity capital. However, such costs have been adjusted to exclude estimated depreciation on rented depreciable-type assets.

YEAR 1966

Adjusted current year's allowable cost	$1,100,000
Adjusted operating cost for 1965[1]	$1,000,000
Percent for determining the allowance	5
Allowance	$50,000
Less estimated depreciation for depreciable-type assets rented prior to 1966 on which rental is paid in 1966	$3,000
Adjusted allowance	$47,000

[1] 1965 operating cost was used in computing the allowance for depreciation based on a percentage of operating costs because it was lower than 1966 allowable cost.

(g) *Limitation on depreciation if optional allowance is used.* This optional allowance only is subject to a limitation based on the provider's total allowable operating cost for the current year. To determine this limitation, compute the sum of the actual depreciation claimed, the allowance based on a percentage of operating costs, and the estimated straight-line depreciation on depreciable-type assets rented after 1965. If this sum exceeds six percent of the provider's current year's allowable cost (exclusive of any actual depreciation claimed, estimated depreciation on rented depreciable-type assets, allowance in lieu of specific recognition of other costs, and return on equity capital), the allowance for depreciation based on a percentage of operating costs is reduced by the amount of excess. In applying this limitation, if the actual depreciation claimed is on an accelerated basis, it must be converted to a straight-line basis only for use in calculating this limitation. It is presumed that pre-1966 assets will not be retired at a greater than normal rate, and the limitation of six percent, as it affects the availability of the allowance, is designed as a safeguard if the presumption is not borne out. If the provider does not elect to use the optional allowance, the combined allowance for depreciation based on costs of pre-1966 assets and those subsequently acquired is not subject to the six percent limitation.

Example No. 1. The following illustration demonstrates how this limitation would be determined.

YEAR 1966

[The provider keeps its records on a calendar year basis. The current year's actual allowable cost and the actual operating cost for 1965 have been adjusted to exclude actual depreciation, the estimated depreciation on rented depreciable-type assets, allowance in lieu of specific recognition of other costs, and return on equity capital.]

Adjusted operating cost for 1965	$1,000,000
Percent for determining the allowance	5
In 1966 assets were acquired which produce a straight-line depreciation of	$18,000
Estimated depreciation on assets rented in 1966	$2,000
Adjusted allowable operating cost for 1966	$1,100,000

YEAR 1966—Continued

CALCULATION OF ALLOWANCE FOR DEPRECIATION BASED ON A PERCENTAGE OF OPERATING COSTS

Gross allowance	
5 percent times adjusted 1965 operating costs ($1,000,000)	$50,000
Estimated depreciation on assets rented in 1966	2,000
Straight-line depreciation on post-1965 assets	18,000
Total	70,000
6 percent of adjusted 1966 allowable operating cost	66,000
Reduction in allowance	4,000
Allowance	50,000
Reduction	4,000
Adjusted allowance	46,000
Total depreciation allowance for 1966 ($18,000 actual depreciation plus $46,000 allowance based on operating cost)	64,000

Assume in this illustration that the provider had elected to use the declining balance method in computing its allowable depreciation and the rental expense for depreciable-type assets was $3,500. In that case, it would include in its 1966 allowable cost not only the $46,000 allowance based on operating costs but also $36,000 (in this instance 2×straight-line rate is used) in actual depreciation and the rental expense of $3,500—or a total of $85,500 covering all its depreciable assets.

§ 413.144 Depreciation: Allowance for depreciation on fully depreciated or partially depreciated assets.

(a) *Principle.* Depreciation on assets being used by a provider at the time it enters into the Medicare program is allowed. This principle applies even though such assets may be fully or partially depreciated on the provider's books.

(b) *Application.* Depreciation is allowable on assets being used at the time the provider enters into the program. This applies even though such assets may be fully depreciated on the provider's books or fully depreciated with respect to other third-party payers. So long as an asset is being used, its useful life is considered not to have ended, and consequently the asset is subject to depreciation based upon a revised estimate of the asset's useful life as determined by the provider and approved by the intermediary. Correction of prior years' depreciation to reflect revision of estimated useful life should be made in the first year of participation in the program unless the provider has used the optional method (§ 413.139), in which case the correction should be made at the time of discontinuing the use of that method. If an asset has become fully depreciated under Medicare, further depreciation is not appropriate or allowable, even though the asset may continue in use.

(c) *Example of an allowance for a fully-depreciated asset.* For example, if a 50-year-old building is in use at the time the provider enters into the program, depreciation is allowable on the building even though it has been fully depreciated on the provider's books. Assuming that a reasonable estimate of the asset's continued life is 20 years (70 years from the date of acquisition), the provider may claim depreciation over the next 20 years—if the asset is in use that long—or a total depreciation of as much as twenty-seventieths of the asset's historical cost.

(d) *Corrections to depreciation.* If the asset is disposed of before the expiration of its estimated useful life, the depreciation would be adjusted to the actual useful life. Likewise, a provider may not have fully depreciated other assets it is using and finds that it has incorrectly estimated the useful lives of those assets. In such cases, the provider may use the corrected useful lives in determining the amount of depreciation, provided such corrections have been approved by the intermediary.

§ 413.149 Depreciation; Allowance for depreciation on assets financed with Federal or public funds.

(a) *Principle.* Depreciation is allowed on assets financed with Hill-Burton or other Federal or public funds.

(b) *Application.* Like other assets (including other donated depreciable assets), assets financed with Hill-Burton or other Federal or public funds become a part of the provider institution's plant and equipment to be used in furnishing services. It is the function of payment of depreciation to provide funds that make it possible to maintain the assets and preserve the capital employed in the production of services. Therefore, irrespective of the source of financing of an asset, if it is used in the providing of services for beneficiaries of the program, payment for depreciation of the asset is, in fact, a cost of the production of those services. Moreover, recognition of this cost is necessary to maintain productive capacity for the future. An incentive for funding of depreciation is provided in these principles by the provision that investment income on funded depreciation is not treated as a reduction of allowable interest expense under § 413.153(a).

§ 413.153 Interest expense.

(a)(1) *Principle.* Necessary and proper interest on both current and capital indebtedness is an allowable cost. However, interest costs are not allowable if incurred as a result of—

(i) Judicial review by a Federal court (as described in § 413.64(j));

(ii) An interest assessment on a determined overpayment (as described in § 405.376 of this chapter); or

(iii) Interest on funds borrowed to repay an overpayment (as described in § 413.64(j) or § 405.376 of this chapter), up to the amount of the overpayment, unless the provider had made a prior commitment to borrow funds for other purposes (for example, capital improvements).

(2) *Exception.* In those cases of administrative or judicial reversal, interest paid on funds borrowed to repay an overpayment is an allowable cost, in accordance with this section.

(b) *Definitions*—(1) *Interest.* Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. This is usually for such purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long-term loans.

(2) *Necessary.* Necessary requires that the interest be—

(i) Incurred on a loan made to satisfy a financial need of the provider. Loans that result in excess funds or investments would not be considered necessary;

(ii) Incurred on a loan made for a purpose reasonably related to patient care; and

(iii) Reduced by investment income except if such income is from gifts and grants, whether restricted or unrestricted, and that are held separate and not commingled with other funds. Income from funded depreciation or a provider's qualified pension fund is not used to reduce interest expense. Interest received as a result of judicial review by a Federal court (as described in § 413.64(j)) is not used to reduce interest expense.

(3) *Proper.* Proper requires that interest be—

(i) Incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made; and

(ii) Paid to a lender not related through control or ownership, or personal relationship to the borrowing organization. However, interest is allowable if paid on loans from the provider's donor-restricted funds, the funded depreciation account, or the provider's qualified pension fund.

(c) *Borrower-lender relationship.* (1) Except as described in paragraph (c)(2) below, to be allowable, interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership, or personal relationship to the borrower. Presence of any of these factors could affect the "bargaining" process that usually accompanies the making of a loan, and could thus be suggestive of an agreement on higher rates of interest or of unnecessary loans. Loans should be made under terms and conditions that a prudent borrower would make in armslength transactions with lending institutions. The intent of this provision is to assure that loans are legitimate and needed, and that the interest rate is reasonable. Thus, interest paid by the provider to partners, stockholders, or related organizations of the provider would not be allowable. If the owner uses his own funds in a business, it is reasonable to treat the funds as invested funds or capital, rather than borrowed funds. Therefore, if interest on loans by partners, stockholders, or related organizations is disallowed as a cost solely because of the relationship factor, the principal of such loans is treated as invested funds in the computation of the provider's equity capital under § 413.157.

(2) Exceptions to the general rule regarding interest on loans from controlled sources of funds are made in the following circumstances. Interest on loans to providers by partners, stockholders, or related organizations made prior to July 1, 1966, is allowable as cost, provided that the terms and conditions of payment of such loans have been maintained in effect without modification subsequent to July 1, 1966. If the general fund of a provider "borrows" from a donor-restricted fund and pays interest to the restricted fund, this interest expense is an allowable cost. The same treatment is accorded interest paid by the general fund on money "borrowed" from the funded depreciation account of the provider or from the provider's qualified pension fund. In addition, if a provider operated by members of a religious order borrows from the order, interest paid to the order is an allowable cost.

(3) If funded depreciation is used for purposes other than improvement, replacement, or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment is accorded deposits in the provider's qualified pension fund if such deposits are used for other than the purpose for which the fund was established.

(d) *Loans not reasonably related to patient care.* (1) The following types of loans are not considered to be for a purpose reasonably related to patient care:

(i) For loans made to finance acquisition of a facility, that portion of the cost that exceeds—

(A) Historical cost as determined under § 413.134(b); or

(B) The cost basis determined under § 413.134(g) and

(ii) Loans made to finance capital stock acquisitions, mergers, or consolidations for which revaluation of assets is not allowed under § 413.134(k)

(2) In determining whether a loan was made for the purpose of acquiring a facility, we will apply any owner's investment or funds first to the tangible assets, then to the intangible assets other than goodwill and lastly to the goodwill. If the owner's investment or funds are not sufficient to cover the cost allowed for tangible assets, we will apply funds borrowed to finance the acquisition to the portion of the allowed cost of the tangible assets not covered by the owner's investment, then to the intangible assets other than goodwill, and lastly to the goodwill

(e) *Limitation on Federal participation for capital expenditures.* The allowance for depreciation is not an allowable cost for certain capital expenditures as described in § 413.161.

§ 413.157 Return on equity capital of proprietary providers.

(a) *Principle*—(1) *Rate of return.* (i) A reasonable return on equity capital invested and used in the provision of patient care is paid as an allowance in addition to the reasonable cost of covered services furnished to beneficiaries by proprietary providers.

(ii) Except as provided in paragraph (a)(1)(iii) of this section, the amount allowable on an annual basis is determined by applying to the provider's equity capital a percentage equal to one and one-half times the average of the rates of interest on special issues of public debt obligations issued to the Medicare Part A Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the program.

(iii) For cost reporting periods beginning on or after April 20, 1983, the amount allowable in determining the return related to inpatient hospital

services is determined using a percentage equal to the average of the rates of interest as described in paragraph (a)(1)(ii) of this section.

(2) *Proprietary providers.* For the purposes of this part the term "proprietary providers" is intended to distinguish providers, whether sole proprietorships, partnerships, or corporations, that are organized and operated with the expectation of earning profit for the owners, from other providers that are organized and operated on a nonprofit basis.

(b) *Application*—(1) *Computation of equity capital.* Proprietary providers generally do not receive public contributions and assistance of Federal and other governmental programs in financing capital expenditures. Proprietary institutions historically have financed capital expenditures through funds invested by owners in the expectation of earning a return. A return on investment, therefore, is needed to avoid withdrawal of capital and to attract additional capital needed for expansion. For purposes of computing the allowable return, the provider's equity capital means—

(i) The provider's investment in plant, property, and equipment related to patient care (net of depreciation) and funds deposited by a provider who leases plant, property, or equipment related to patient care and is required by the terms of the lease to deposit such funds (net of noncurrent debt related to such investment or deposited funds); and

(ii) Net working capital maintained for necessary and proper operation of patient care activities. However, debt representing loans from partners, stockholders, or related organizations on which interest payments would be allowable as costs but for the provisions of § 413.153(b)(3)(ii), is not subtracted in computing the amount of equity capital as defined in paragraph (b)(1)(i) of this section and this paragraph (b)(1)(ii), in order that the proceeds from such loans be treated as a part of the provider's equity capital. In computing the amount of equity capital upon which a return is allowable, investment in facilities is recognized on the basis of the historical cost, or other basis, used for depreciation and other purposes under the Medicare program.

(2) *Acquisitions after July 1970.* With respect to a facility or any tangible assets of a facility acquired on or after August 1, 1970, the excess of the price paid for such facility or such tangible assets over the historical cost, as defined in § 413.134(b), or the cost basis, as determined under § 413.134(g) (whichever is appropriate), is not includable in equity capital, and loans made to finance such excess portion of the cost of such acquisitions (see § 413.153(d)) are excluded in computing equity capital.

(3) *Acquisitions prior to August 1970.* With respect to a facility or any tangible assets of a facility acquired before August 1970, the excess of the price paid for such facility or assets over the fair market value of tangible assets at the time of purchase is includable in equity capital to the extent that it is reasonable except that the cumulative allowable return for such excess may not exceed 100 percent of such excess. For purposes of this section, the cumulative allowable return means the sum of the allowable rate of return on equity capital for all months starting from August 1, 1970. For example, if the allowable rates of return on equity capital for a provider are 9 percent for the first year (and such year started August 1, 1970), 8.5 percent for the second year, and 10.5 percent for the third year, the cumulative allowable return at the end of the third year would be 28 percent. After the cumulative allowable return equals 100 percent, the inclusion in equity capital of the excess is no longer allowable.

(4) *Computation of return on equity capital.* For purposes of computing the allowable return, the amount of equity capital is the average investment during the reporting period. The rate of return allowed as derived from time to time based upon interest rates in accordance with this principle, is determined by HCFA and communicated through intermediaries. Return on investment as an element of allowable costs is subject to apportionment in the same manner as other elements of allowable costs.

Example of calculation of cumulative allowable return. X purchased a provider on July 1, 1969, paying $100,000 in excess of the fair market value of the assets acquired. Provider X files its cost report on a calendar-year basis. The allowable rate of return on equity capital for August 1, 1970-December 31, 1970 (4.538 percent), is obtained by multiplying the allowable rate of return for the period ending December 31, 1970 (10.891) by 5/12 (a fraction of which the numerator is the number of months from August 1, 1970, to the end of the cost-reporting period and the denominator is the number of months in the cost-reporting period). The cumulative allowable return for Provider X for the period August 1, 1970-December 31, 1973, (32.367 percent) is computed as follows:

Cost reporting year ending	Rate of return on equity capital (percent)
Dec. 31, 1970	4.538
Dec. 31, 1971	8.969
Dec. 31, 1972	8.891
Dec. 31, 1973	9.969
Total	32.367

(The $100,000 paid in excess of the fair market value of the assets acquired is included in equity capital until the sum of the allowable rate of return on equity capital equals 100 percent. Of course, no portion of the $100,000 may be amortized as an allowable cost or is otherwise allowable for any program reimbursement purposes other than for determining the provider's equity capital.

(5) *Unapproved capital; expenditures.* Effective with respect to any capital expenditure, the obligation for which is incurred after December 31, 1972, or after the effective date of an agreement executed between a State and the Secretary pursuant to section 1122 of the Act, whichever date is later (and subject to the exceptions in § 413.161(c)), a provider's investment in plant, property, and equipment related to patient care, and funds deposited by a provider which leases plant, property, or equipment related to patient care that are found to be expenditures which have not been submitted to the designated planning agency are required or have been determined to be inconsistent with health facility planning requirements (as described in §§ 100.101 through 100.109 of this title) are not included in the provider's equity capital for computing the allowance for a reasonable return on equity capital.

§ 413.161 Nonallowable costs related to certain capital expenditures.

(a) *Principle.* Effective with respect to any capital expenditure, as defined in Part 100 of this title, the obligation for which is incurred after December 31, 1972, or after the effective date of an agreement executed between a State and the Secretary pursuant to section 1122 of the Act, whichever date is later, the depreciation, interest on borrowed funds, return on equity capital (in the case of proprietary providers), and any other costs attributable to such capital expenditure, for which the Secretary has determined that such proposed capital expenditure has not been submitted to the designated planning agency as required, or that it has been determined by such agency to be inconsistent with the standards, plans, or criteria developed to meet the need for adequate health care facilities (as defined in § 100.101 through § 100.109 of this title) are not allowable. Other costs related to such capital expenditures include title

fees; permit and license fees; broker commissions; architect, legal, accounting, and appraisal fees; interest, finance, or carrying charges on bonds, or notes; and other costs incurred for borrowing funds. The reasonable costs incurred by a provider for studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisitions, improvement, expansion, or replacement of the plant and equipment that are conducted to enable the provider to properly determine whether the proposed capital expenditure would be in compliance with the standards, plans, or criteria developed by the designated planning agency are allowable, except if the provider makes the capital expenditure and does not receive the required approval.

(b) *Applicability.* Under the principle specified in paragraph (a) of this section, any costs related to capital expenditures, the obligation for which was incurred by or on behalf of a provider subsequent to 1972 (except as described in paragraph (c) of this section), are not allowable if the Secretary has determined that the capital expenditures have not been submitted to the designated planning agency as required or that they have been determined to be inconsistent with the standards, plans, or criteria developed by the designated planning agency or other health planning agency in the State to meet the need for adequate health care facilities in the area covered by the plan or plans so developed (see §§ 100.101 through 100.109 of this title). Costs claimed by a provider in connection with capital assets that are donated or transferred to a provider are also subject to the application of such principle. Such principle also applies to the reasonable equivalent of that portion of any rental expense incurred pursuant to a lease or a comparable arrangement (and to any amounts deposited under the terms of such a lease or comparable arrangement in computing the return on equity capital) that would have been excluded had the provider acquired such a facility or equipment by purchase. The amounts excluded are not subject to reimbursement under any other provisions of Medicare.

(c) *Exceptions.* The limitation on recognition of costs attributable to capital expenditures discussed in this section does not apply to the following:

(1) A provider furnishing health care services as of December 18, 1970, that on such date was committed to a formal plan of expansion or replacement, with respect to such expenditures as may be made or such obligations as may be incurred for capital items included in such plan for which preliminary expenditures toward the plan of expansion or replacement (including payments for studies, surveys, designs, plans, working drawings, specifications, and site acquisition, essential to the acquisition, improvement, expansion, or replacement of the health care facility or equipment concerned) of $100,000 or more, had been made during the three-year period ending December 17, 1970.

(2) Christian Science sanatoria operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

(3) Capital expenditures the obligations for which were incurred by or on behalf of a provider prior to 1973.

(4) Capital expenditures the exclusion of which the Secretary has determined would—

(i) Discourage the operation or expansion of a provider that has demonstrated its capability of providing comprehensive health care services efficiently, effectively, and economically; or

(ii) Otherwise be inconsistent with the effective organization and delivery of health services or the effective administration of Title V, XVIII, or XIX of the Act.

(d) *Appeals.* See § 405.1890 of this chapter for appeal rights of a provider or other person dissatisfied with a determination under section 1122 of the Act (42 U.S.C. 1320a–1).

Subpart H—Payment for End-Stage Renal Disease (ESRD) Services

§ 413.170 Payments for covered outpatient maintenance dialysis treatments.

(a) *Basis and purpose.* This section implements section 1881 (b)(2) and (b)(7) of the Act by—

(1) Setting forth the principles and authorities under which HCFA is authorized to establish a prospective reimbursement system for outpatient maintenance dialysis furnished in or under the supervision of an ESRD facility approved under Subpart U of Part 405 of this chapter (referred to as "facility" in this section). For purposes of this section and § 413.174, outpatient maintenance dialysis means outpatient dialysis, home dialysis and self-dialysis, and home dialysis training as defined in § 405.2102 (f)(2)(ii), (f)(2)(iii), and (f)(3) of this chapter, and includes all items and services specified in § 405.231 (o) and (p) of this chapter.

(2) Providing for procedures and criteria under which a facility may receive an exception to the prospective payment rates established under this section; and

(3) Establishing procedures and criteria for a facility to appeal its reimbursement under the prospective reimbursement system.

(b) *Principles of prospective reimbursement.* (1) Under prospective reimbursement, payments for outpatient maintenance dialysis are based on rates set prospectively by HCFA.

(2) All approved ESRD facilities must accept the prospective payment rates established by HCFA as payment in full for covered outpatient maintenance dialysis.

(3) HCFA will publish the methodology used to establish rates and changes in payment rates in the **Federal Register**, as provided in paragraph (i)(2) of this section.

(c) *Prospective rates for hospital-based and independent ESRD facilities.* (1) In accordance with section 1881(b)(7) of the Act, HCFA will establish prospective rates by a methodology that—

(i) Differentiates between hospital-based facilities and independent ESRD facilities;

(ii) Effectively encourages efficient delivery of dialysis services; and

(iii) Provides incentives for increasing the use of home dialysis.

(2) For purposes of rate-setting and reimbursement under this section, HCFA will consider any facility that does not meet all of the criteria of a hospital-based facility to be an independent facility. A determination under this paragraph is an initial determination under § 405.1502 of this chapter.

(3) For purposes of rate-setting and reimbursement under this section, HCFA will determine that a facility is hospital-based if the—

(i) Facility and hospital are subject to the bylaws and operating decisions of a common governing board. All authority in management flows from this governing board, which has final administrative responsibility, approves all personnel actions, appoints medical staff, and carries out similar management functions;

(ii) Facility's director or administrator is under the supervision of the hospital's chief executive officer and reports through him or her to the governing board;

(iii) Facility personnel policies and practices conform to those of the hospital;

(iv) Administrative functions of the facility (for example, records, billing, laundry, housekeeping, and purchasing)

are integrated with those of the hospital; and

(v) Facility and hospital are financially integrated, as evidenced by the cost report, which must reflect allocation of overhead to the facility through the required step-down methodology.

(4) In determining whether a facility is hospital-based, HCFA will not consider—

(i) An agreement between a facility and a hospital concerning patient referral;

(ii) A shared service arrangement between a facility and a hospital; or

(iii) The physical location of a facility on the premises of a hospital.

(d) *Amount of payments.* (1) If the beneficiary has incurred the full deductible applicable under Part B of Medicare before the treatment, the intermediary will pay the facility 80 percent of its prospective payment rate.

(2) If the beneficiary has not incurred the full deductible applicable under Part B of Medicare before the treatment, the intermediary will subtract the amount applicable to the deductible from the facility's prospective rate, and will pay the facility 80 percent of the remainder, if any.

(e) *Bad debts.* (1) HCFA will reimburse each facility its allowable Medicare bad debts, up to the facility's costs as determined under Medicare principles, in a single lump sum at the end of the facility's cost reporting period.

(2) A facility must attempt to collect deductible and coinsurance amounts owed by beneficiaries before requesting reimbursement from HCFA for uncollectible amounts. Section 413.80 specifies the efforts facilities must make.

(3) A facility must request reimbursement for uncollectible deductible and coinsurance amounts owed by beneficiaries by submitting an itemized list of all specific non-collections related to covered services.

(f) *Procedures for requesting exceptions to payment rates.* (1) All payments for outpatient maintenance dialysis furnished at or through facilities will be made on the basis of prospective payment rates, without exemption.

(2) If a facility projects on the basis of prior year cost and utilization trends that it will have an allowable cost per treatment higher than its prospective rate set under this section, and if these excess costs are attributable to factors related to one or more of the criteria in paragraph (g) of this section, the facility may request HCFA to approve an exception to that rate and set a higher prospective payment rate.

(3) This higher payment rate will be subject to the rules governing the amount of payment in paragraph (d) of this section.

(4) A facility must request an exception to its payment rate within 180 days after—

(i) It is notified of its prospective payment rate; or

(ii) An extraordinary event with substantial cost effects, as described in paragraph (g)(4) of this section.

(5) The facility is responsible for demonstrating to HCFA's satisfaction that the requirements of this section, including the criteria in paragraph (g), are met in full. That is, the burden of proof is on the facility to show that one or more of the criteria are met, and that the excessive costs are justifiable under the reasonable cost principles set forth in this part. The burden of proof is not on HCFA to show that the criteria are not met, and that the facility's costs are not allowable.

(6) If requesting an exception to its payment rate, a facility must submit to HCFA its most recently completed cost report as required under § 413.174, and whatever statistics, data, and budgetary projections are determined by HCFA to be needed to determine if the exception is approvable. HCFA may audit any cost report or other information submitted. The materials submitted to HCFA must—

(i) Separately identify elements of cost contributing to costs per treatment in excess of the facility's payment rate;

(ii) Show that all of the facility's costs, including those costs that are not directly attributable to the exception criteria, are allowable and reasonable under the reasonable cost principles set forth in this part.

(iii) Show that the elements of excessive cost are specifically attributable to one or more conditions specified by the criteria set forth in paragraph (g) of this section; and

(iv) Specify the amount of additional reimbursement per treatment the facility believes is required in order to recover its justifiable excess costs.

(7) HCFA will accept an exception request on the date that HCFA concludes that it has received all materials necessary to determine if the exception is approvable.

(8) In determining the facility's payment rate under the exception process, HCFA will exclude all costs that are not allowable under the reasonable cost principles set forth in this part.

(9) Except for exceptions approved under paragraph (g)(4) of this section, a prospective exception payment rate approved by HCFA will apply for the period from the date the exception request was accepted until the earlier of the—

(i) Date the circumstances justifying the exception rate no longer exist; or

(ii) End of the 12-month period during which the announced rate was to apply.

(10) A prospective exception payment rate approved by HCFA under paragraph (g)(4) of this section will apply from the date of the extraordinary event until the end of the 12-month period during which the announced rate was to apply, unless HCFA determines that another date is more appropriate. If HCFA does not extend the exception period, and the facility believes that it continues to require an exception to its rate, the facility must reapply in accordance with paragraph (f) of this section.

(g) *Criteria for approval of exception requests.* HCFA may approve exceptions to an ESRD facility's prospective payment rate if the facility demonstrates with convincing objective evidence that its total per treatment costs are reasonable and allowable under § 413.174, and that its per treatment costs in excess of its payment rate are directly attributable to any of the following criteria:

(1) *Atypical service intensity (patient mix).* A substantial proportion of the facility's outpatient maintenance dialysis treatments involve atypically intense dialysis services, special dialysis procedures, or supplies that are medically necessary to meet special medical needs of the facility's patients. The facility is able to demonstrate clearly that these services, procedures or supplies and its per treatment costs are prudent and reasonable when compared to those of facilities with a similar patient mix. Examples that may qualify under this criterion are more intense dialysis services that are medically necessary for patients such as—

(i) Patients who have been referred from other facilities on a temporary basis for more intense care during a period of medical instability, and who return to the original facility after stabilization;

(ii) Pediatric patients, who require a significantly higher staff-to-patient ratio than typical adult patients; or

(iii) Patients with medical conditions that are not commonly treated by ESRD facilities, and that complicate the dialysis procedure.

(2) *Isolated essential facility.* The facility is the only supplier of dialysis in its geographical area, its patients cannot obtain dialysis services elsewhere without substantial additional hardship.

and its excess costs are justifiable. HCFA will consider local permanent residential population density, typical local commuting distances for medical services, volume or treatments, and dialysis facility usage by area residents other than the applying facility's patients, in determining whether an exception requested on this is approvable.

(3) *Education costs.* The facility has excess costs attributable to an approved nursing education program or intern-resident program as specified in § 413.85. The amount of the increase in the facility's rate is limited to the amount that is properly allocated to the outpatient dialysis department, and to what is reasonable when compared to the costs of other similar facilities that have educational programs.

(4) *Extraordinary circumstances.* The facility incurs excess costs beyond its control due to a fire, earthquake, flood, or other natural disaster. HCFA will not recognize such costs in cases when a facility chose not to maintain adequate insurance protection against such losses (through the purchase of insurance, the maintenance of a self-insurance program, or other equivalent alternative) or chose not to file a claim for losses covered by insurance, or not to utilize its self-insurance program.

(5) *Self-dialysis Training Costs.* The facility incurs per treatment costs for furnishing self-dialysis and home dialysis training that exceed the facility's payment rate for such training sessions.

(6) *Frequency of Dialysis.* The facility has a substantial proportion of patients who dialyze less frequently than three times per week. Per treatment payment rates granted under this exception will be no more than the amount that results in weekly reimbursement per patient equal to three times the facility's prospective composite rate, exclusive of any exception amounts.

(h) *Appeals.* (1) *Appeals under section 1878 of the Act.* A facility that disputes the amount of its allowable Medicare bad debts reimbursed by HCFA under paragraph (e) of this section may request a review from the intermediary or the Provider Reimbursement Review Board (PRRB) in accordance with subpart R of Part 405 of this chapter.

(2) *Other Appeals.* A facility that has requested higher payment per treatment in accordance with paragraph (f) of this section may request a review from the intermediary or the PRRB if HCFA has denied the request in whole or in part. In such a case, the procedure in subpart R of Part 405 of this chapter will be followed to the extent that it is applicable. The PRRB, subject to review by the Administrator under § 405.1875 of this chapter, will have the authority to determine whether the HCFA action under review conformed to the provisions of paragraph (f).

(3) *Procedure.* (i) The facility must request a review within 180 days of the date of the decision on which review is sought.

(ii) The facility may not submit to the intermediary or the PRRB any additional information or cost data that were not submitted to HCFA at the time the facility requested an exception to its prospective payment rate.

(4) *Determining amount in controversy.* For purposes of determining PRRB jurisdiction under Subpart R of Part 405 of this chapter for the appeals described in paragraph (h)(2) of this section—

(i) The amount in controversy per treatment will be determined by subtracting the amount of program payment from the amount the facility requested under paragraph (f) of this section; and

(ii) The total amount in controversy will be calculated by multiplying the amount per treatment by the projected estimated number of treatments for the exception request period (as specified in paragraphs (f) (7) and (8) of this section).

(i) *Notification of changes in rate-setting methodologies and payment rates.* (1) HCFA or the facility's intermediary will notify each facility annually of its payment rate. This notice will include changes in individual facility payment rates resulting from corrections or revisions of particular geographic labor cost adjustment factors.

(2) Changes in payment rates resulting from incorporation of updated cost data, or general revisions of geographic labor cost adjustment factors, will be announced by notice published in the **Federal Register** without opportunity for prior public comment. Other revisions of the rate-setting methodology will be published in the **Federal Register** in accordance with the Department's established rulemaking procedures.

§ 413.174 Recordkeeping and cost reporting requirements for outpatient maintenance dialysis.

(a) *Purpose and scope.* This section implements section 1881(b)(2)(B)(i) of the Act by specifying recordkeeping and cost reporting requirements for ESRD facilities approved under Subpart U of Part 405 of this chapter. The records and reports will enable HCFA to detemine the costs incurred in furnishing outpatient maintenance dialysis as defined in § 413.170(a)(1).

(b) *Recordkeeping and reporting requirements.* (1) Each facility must keep adequate records and submit the appropriate HCFA-approved cost report in accordance with §§ 413.20 and 413.24, which provide rules on financial data and reports, and adequate cost data and cost finding, respectively.

(2) The cost reimbursement principal set forth in this part (beginning with § 413.134, Depreciation, and excluding the principles listed in paragraph (b)(4) of this section), apply in the determination and reporting of the allowable cost incurred in furnishing outpatient maintenance dialysis treatments to patients dialyzing in the facility, or incurred by the facility in furnishing home dialysis services, supplies, and equipment.

(3) Allowable cost is the reasonable cost related to dialysis treatments. Reasonable cost includes all necessary and proper expenses incurred by the facility in furnishing the dialysis treatments, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. Reasonable cost does not include costs that—

(i) Are not related to patient care for outpatient maintenance dialysis;

(ii) Are for services or items specifically not reimbursable under the program;

(iii) Flow from the provision of luxury items or services (items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services); or

(iv) Are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors.

(4) The following principles of this part do not apply in determining adjustments to allowable costs as reported by ESRD facilities:

(i) Section 413.157, Return on equity capital of proprietary providers;

(ii) Section 413.178, Reimbursement of OPAs and histocompatibility laboratories;

(iii) Section 413.9, Cost related to patient care (except for the principles stated in paragraph (b)(3) of this section); and

(iv) Sections 413.64, Payment to providers, and § 413.13, § 413.30, § 413.35, § 413.40, § 413.74, § 413.56, and § 405.465 through § 405.482 of this chapter, Effect of principles.

§ 413.178 Reimbursement of independent organ procurement agencies and histocompatibility laboratories.

(a) *Principle.* Covered services furnished after September 30, 1978 by organ procurement agencies (OPAs) and histocompatibility laboratories in connection with kidney acquisition and transplantation will be reimbursed under the principles for determining reasonable cost contained in this part. Services furnished by independent OPAs and histocompatibility laboratories, that have an agreement with the Secretary in accordance with paragraph (c) of this section, will be reimbursed by making an interim payment to the transplant hospitals using these services and by making a retroactive adjustment, directly with the OPA or laboratory, based upon a cost report filed by the OPA or laboratory. (The reasonable costs of services furnished by hospital based OPAs or laboratories will be reimbursed in accordance with the principles contained in §§ 413.60 and 413.64.)

(b) *Definitions.* For purposes of this section:

(1) "OPA" means an organization that meets the definition in § 405.2102(q) of this chapter.

(2) "Histocompatibility laboratory" means a laboratory meeting the standards and providing the services set forth in § 405.2171(d) of this chapter.

(3) "Independent"—An OPA or a histocompatibility laboratory is independent unless it—

(i) Performs services exclusively for one hospital;

(ii) Is subject to the control of the hospital in regard to the hiring, firing, training and paying of employees; and

(iii) Is considered as a department of the hospital for insurance purposes (including malpractice insurance, general liability insurance, worker's compensation insurance, and employee retirement insurance).

(c) *Agreements with independent OPAs and laboratories.* (1) Any independent OPA or histocompatibility laboratory that wishes to have the cost of its pretransplant services reimbursed under the Medicare program must file an agreement with HCFA under which the OPA or laboratory agrees—

(i) To file a cost report in accourdance with § 413.24(f) within three months after the end of each fiscal year;

(ii) To permit HCFA to designate an intermediary to determine the interim reimbursement rate payable to the transplant hospitals for services provided by the OPA or laboratory and to make a determination of reasonable cost based upon the cost report filed by the OPA or laboratory;

(iii) To provide such budget or cost projection information as may be required to establish an initial interim reimbursement rate;

(iv) To pay to HCFA amounts that have been paid by HCFA to transplant hospitals and that are determined to be in excess of the reasonable cost of the services provided by the OPA or laboratory; and

(v) Not to charge any individual for items or services for which that individual is entitled to have payment made under section 1881 of the Act.

(2) An independent OPA or histocompatibility laboratory whose services were being reimbursed under Medicare on October 1, 1978, and that wishes to continue being reimbursed under Medicare must file an agreement by January 13, 1979.

(3) The initial cost report due from an OPA or laboratory is for its first fiscal year ending after September 30, 1978, during any portion of which it had an agreement with the Secretary under paragraph (c) (1) and (2) of this section. The initial cost report covers only the period covered by the agreement.

(d) *Interim reimbursement.* (1) Hospitals eligible to receive Medicare reimbursement for renal transplantation will be paid for the pretransplantation services of an independent OPA or histocompatibility laboratory that has an agreement with the Secretary under paragraph (c) of this section, on the basis of an interim rate established by an intermediary for that OPA or laboratory.

(2) The interim rate will be based on the average cost per service incurred by an OPA or laboratory, during its previous fiscal year, associated with procuring a kidney for transplantation. This interim rate may be adjusted if necessary for anticipated cost changes. If there is not adequate cost data to determine the initial interim rate, it will be determined according to the OPA's or laboratory's estimate of its projected costs for the fiscal year.

(3) Payments made on the basis of the interim rate will be reconciled directly with the OPA or laboratory after the close of its fiscal year, in accordance with paragraph (e) of this section.

(4) Information on the interim rate for all independent OPA's and histocompatibility laboratories shall be disseminated to all transplant hospitals and intermediaries.

(e) *Retroactive adjustment.* (1) *Cost reports.* Information provided in cost reports by independent OPA's and histocompatibility laboratories must meet the requirements for cost data and cost finding specified in paragraphs (a) through (e) of § 413.24. These cost reports must provide a complete accounting of the cost incurred by the agency or laboratory in providing covered services, the total number of Medicare beneficiaries who received those services, and any other data necessary to enable the intermediary to make a determination of the reasonable cost of covered services provided to Medicare beneficiaries.

(2) *Audit and adjustment.* A cost report submitted by an independent OPA or histocompatibility laboratory will be reviewed by the intermediary and a new interim reimbursement rate for the succeeding fiscal year will be established based upon this review. A retroactive adjustment in the amount paid under the interim rate will be made in accordance with § 413.64(f). If the determination of reasonable cost reveals an overpayment or underpayment resulting from the interim reimbursement rate paid to transplant hospitals, a lump sum adjustment will be made directly between the intermediary and the OPA or laboratory.

(f) *Appeals.* Any OPA or histocompatibility laboratory that disagrees with an intermediary's cost determination under this section is entitled to an intermediary hearing, in accordance with the procedures contained in §§ 405.1811 through 405.1833, if the amount in controversy is $1,000 or more.

VI. Part 416 is amended as follows:

PART 416—AMBULATORY SURGICAL SERVICES

A. The authority citation for Part 416 continues to read as follows:

Authority: Secs. 1102, 1832(a)(2), 1833, 1863, and 1864 of the Social Security Act (42 U.S.C. 1302, 1395k(a)(2), 1395l, 1395z, and 1395aa).

§ 416.120 [Amended]

B. In § 416.120 (a) and (b), references to "Part 405, Subpart D" are changed to read "Part 413."

PART 417—HEALTH MAINTENANCE ORGANIZATIONS, COMPETITIVE MEDICAL PLANS AND HEALTH CARE PREPAYMENT PLANS

VII. A. The authority citation for Part 417 continues to read as follows:

Authority: Secs. 1102, 1833(a)(1)(A), 1861(s)(2)(H), 1871, 1874, and 1876 of the Social Security Act as amended (42 U.S.C. 1302, 1395l(a)(1)(A), 1395x(s)(2)(H), 1395hh, 1395kk, and 1395mm); section 114(c) of Pub. L. 97-248 (42 U.S.C. 1395mm note); and section 1301 of the Public Health Service Act (42 U.S.C. 300e).

B. Subpart B is amended as follows:

Subpart B—Health Maintenance Organizations

§ 417.240 [Amended]

1. In § 417.240(a), reference to "Subpart D of Part 405" is changed to read "Parts 412 and 413."

§ 417.241 [Amended]

2. a. In § 417.241(b), reference to "§ 405.402" is changed to read "§ 413.5 of this chapter."

b. In § 417.241(d), reference to "Subpart D of Part 405" is changed to read "Parts 412 and 413."

§ 417.242 [Amended]

3. a. In § 417.242(b), reference to "Subpart D of Part 405" is changed to read "Parts 412 and 413."

b. In § 417.242(b)(1), reference to "§§ 405.415, 405.417, and 405.418" is changed to read "§§ 413.134, 413.144, and 413.149 of this chapter."

c. In § 417.242(b)(2), reference to "§ 405.419" is changed to read "§ 413.153 of this chapter."

d. In § 417.242, paragraphs (b)(3) and (b)(4), reference to "§ 405.420" is changed to read "§ 413.80 of this chapter."

e. In § 417.242(b)(5), reference to "§ 405.421" is changed to read "§ 413.85 of this chapter."

f. In § 417.242(b)(6), reference to "§ 405.422" is changed to read "§ 413.90 of this chapter."

g. In § 417.242(b)(8), reference to "§ 405.424" is changed to read "§ 413.94 of this chapter."

h. In § 417.242(b)(9), reference to "§ 405.425" is changed to read "§ 413.98 of this chapter."

i. In § 417.242(b)(10), reference to "§ 405.426" is changed to read "§ 413.102 of this chapter."

j. In § 417.242(b)(11), reference to "§ 405.427" is changed to read "§ 413.17 of this chapter."

k. In § 417.242(b)(12), reference to "§ 405.429" is changed to read "§ 413.157 of this chapter."

l. In § 417.242(b)(13), reference to "§§ 405.402, 405.415, 405.419, 405.429, and 405.435" is changed to read "§§ 413.5, 413.134, 413.153, 413.157, and 413.161 of this chapter."

m. In § 417.242(b)(14)(i)(*a*), reference to "§ 405.402(g) and § 405.502(e)" is changed to read "§§ 405.502(e) and 413.5(f) of this chapter."

n. In § 417.242(b)(14)(i)(*b*), reference to "§ 405.460" is changed to read "§ 413.30 of this chapter."

o. In § 417.242(b)(14)(i)(*c*), reference to "§ 405.432" is changed to read "§ 413.106 of this chapter.".

p. In § 417.242(b)(14)(i)(*d*), reference to "§ 405.433" is changed to read "§ 413.110 of this chapter."

q. In § 417.242(d)(14)(ii), reference to "§ 405.455" is changed to read "§ 413.13 of this chapter."

r. In § 417.242(h), reference to "Subpart D of Part 405" is changed to read "Parts 412 and 413."

§ 417.243 [Amended]

4. a. In § 417.243(b)(1), reference to "§§ 405.452, 405.453, and 405.480" is changed to read "§§ 405.480, 413.55, and 413.24 of this chapter" and reference to § 405.401" is changed to read "§ 413.1 of this chapter."

b. In § 417.243(b)(3), references to "Subpart D of Part 405" are changed to read "Parts 412 and 413."

c. In § 417.243(g), the second footnote in the table, reference to "Subpart D of Part 405" is changed to read "Parts 412 and 413."

§ 417.244 [Amended]

5. In § 417.244(c), reference to "Subpart D of Part 405" is changed to read "Parts 412 and 413," and reference to "§ 405.453" is changed to read "§ 413.24 of this chapter."

§ 417.247 [Amended]

6. In § 417.247, all references to "Subpart D of Part 405" are changed to read "Parts 412 and 413."

§ 417.254. [Amended]

7. In § 417.254(c), references to "Subpart D of Part 405" are changed to read "Parts 412 and 413."

C. Subpart C is amended as follows:

Subpart C—Health Maintenance Organizations and Competitive Medical Plans.

§ 417.530 [Amended]

1. In § 417.530, reference to "Subpart D of Part 405" is changed to read "Parts 412 and 413."

§ 417.532 [Amended]

2. In § 417.532(g), reference to "Subpart D of Part 405" is changed to read "Parts 412 and 413."

§ 417.536 [Amended]

3.a. In § 417.536(a), reference to "Subpart D of Part 405" is changed to read "Parts 412 and 413."

b. In § 417.536(d), reference to "§§ 405.415, 405.417, and 405.418" is changed to read "§§ 413.134, 413.144, and 413.149."

c. In § 417.536(c), reference to "§ 405.419" is changed to read "§ 413.153."

d. In § 417.536(d), reference to "§ 405.421" is changed to read "§ 413.85."

e. In § 417.536(e), reference to "§ 405.426" is changed to read "§ 413.102."

f. In § 417.536(f), reference to "§ 405.420" are changed to read "413.80."

g. In § 417.536(h), reference to "§ 405.422" is changed to read "§ 413.90."

h. In § 417.536, reference to "§ 405.424" and "§ 405.425" respectively are changed to read "§ 413.94" and "§ 413.98."

i. In § 417.536(k), reference to "§ 405.427" is changed to read "§ 413.17."

j. In § 417.536(l), reference to "§ 405.429" is changed to read "§ 413.157."

k. In § 417.536(m), introductory text, reference to "Subparts D and E of Part 405" is changed to read "Subpart E of Part 405, and Parts 412 and 413."

l. In § 417.536(m)(1), reference to "§ 405.439, 405.542, and 405.544" is changed to read "§§ 405.542, 405.544, and 413.170."

m. In § 417.536(m)(2), reference to "§ 405.432" is changed to read "§ 413.106."

n. In § 417.536(m)(3), reference to "§ 405.433" is changed to read "§ 413.110."

o. In § 417.536(m)(4), reference to "§ 405.460" is changed to read "§ 413.30."

p. In § 417.536(m)(5), reference to "§ 405.455" is changed to read "§ 413.13."

§ 417.548 [Amended]

a. In § 417.548, all references to "Subpart D of Part 405" are changed to read "Parts 412 and 413."

b. In § 417.548, the introductory text to paragraph (b), reference to "Part 405" is changed to read "Parts 405, 412, and 413."

§ 417.554 [Amended]

5. In § 417.554, §"§ 405.452, 405.453, 405.480 of this chapter, and in Part 412 of this chapter" is changed to read "§ 405.480, Part 412 of this chapter, and §§ 413.55 and 413.24."

§ 417.558 [Amended]

6. In § 417.558, all references to "Subpart D of Part 405" are changed to read "Parts 412 and 413."

§ 417.568 [Amended]

7. In § 417.568(c), reference to "Subpart D of Part 405" is changed to read "Parts 412 and 413" and reference to ""§ 405.453" is changed to read "§ 413.24."

§ 417.576 [Amended]

8. In § 417.576, all references to "Subpart D of Part 405" are changed to read "Parts 412 and 413."

§ 417.586 [Amended]

9. In § 417.586(b)(2), reference to "Subpart D of Part 405" is changed to read "Parts 412 and 413."

D. Subpart D is amended as follows:

Subpart D—Health Care Prepayment Plans

§ 417.800 [Amended]

1. In § 417.800(d)(1), reference to "Subpart D of Part 405" is changed to read "Parts 412 and 413."

VIII. Part 420, Subpart D is amended as follows:

PART 420—PROGRAM INTEGRITY

Subpart D—Access to Books, Documents, and Records of Subcontractors

A. The authority citation for Subpart D continues to read as follows:

Authority: Secs. 1102, 1861(u), 1861(v), 1862(d), 1862(e), 1866(b), 1871, 1902(a), and 1903(i) of the Social Security Act (42 U.S.C. 1302, 1395x(u), 1395x(v), 1395y(d), 1395y(e), 1395cc(b), 1395hh, 1396(a), and 1396b(i)).

§ 420.301 [Amended]

B. 1. In § 420.301 reference to "§ 405.427" is changed to read "§ 413.17."

IX. Part 421, Subpart C is amended as follows:

PART 421—INTERMEDIARIES AND CARRIERS

Subpart C—Carriers

A. The authority citation for Part 421 continues to read as follows:

Authority: Secs. 1102, 1815, 1816, 1833, 1842, 1861(u), 1871, 1874, and 1875 of the Social Security Act (42 U.S.C. 1302, 1395g, 1395h, 1395l, 1395u, 1395x(u), 1395hh, 1395kk, and 1395ll), and 42 U.S.C. 1395b–1.

§ 421.200 [Amended]

B. 1. In § 421.200(b), reference to "Part 405, Subpart D," is changed to read "Parts 413."

X. Part 447 is amended as follows:

PART 447—PAYMENTS FOR SERVICES

A. The authority citation for Part 447 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302) unless otherwise noted.

B. Subpart C is amended as follows:

Subpart C—Payment for Inpatient Hospital and Long-Term Care Facility Services

§ 447.252 [Amended]

1. In § 447.252(c), reference to "§ 405.460" is changed to read "§ 413.30."

C. Subpart D is amended as follows:

Subpart D—Payment Methods for Other Institutional and Noninstitutional Services

§ 447.371 [Amended]

1. In § 447.371(a) reference to "Subpart D of Part 405" is changed to read "Part 413."

XI. Part 482 is amended as follows:

PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

A. The authority citation for Part 482 continues to read as follows:

Authority: Secs. 1102, 1814(a)(7), 1861(e), (f), (k), (r), (v)(l)(G), and (z), 1864, 1871, 1883, 1886, and 1905(a) of the Social Security Act (42 U.S.C. 1302, 1395f(a)(7), 1395x(e), (f), (k), (r), (v)(l)(G), and (z), 1395aa, 1395hh, 1395tt, 1395ww, 1396d(a)).

B. Subpart E is amended as follows:

Subpart E—Requirements for Specialty Hospitals

§ 482.66 [Amended]

1. In § 482.66, the introductory text to paragraph (a), reference to "§ 405.434" is changed to read "§ 413.114 of this chapter."

2. In § 482.66(a)(1), reference to "§ 405.453(d)(5)" is changed to read "§ 413.24(d)(5) of this chapter."

XII. Part 489 is amended as follows:

PART 489—PROVIDER AGREEMENTS UNDER MEDICARE

A. The authority citation for Part 489 continues to read as follows:

Authority: Secs. 1102, 1861, 1864, 1866, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x, 1395aa, 1395cc, and 1395hh).

B. Subpart A is amended as follows:

Subpart A—General Provisions

§ 489.12 [Amended]

1. In § 489.12(b)(2), reference to "§ 405.454(k)" is changed to read "§ 413.64(i)."

C. Subpart C is amended as follows:

Subpart C—Allowable Charges

§ 489.32 [Amended

1. In § 489.32(b), reference to "§ 405.461" is changed to read "§ 413.35."

(Catalog of Federal Domestic Assistance Programs: No. 13773, Medicare—Hospital Insurance. No. 13774, Medicare—Supplementary Medical Insurance)

Dated: July 10, 1986.

William L. Roper,

Administrator, Health Care Financing Administration.

Approved: September 15, 1986.

Otis R. Bowen,

Secretary.

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